



“The screams aren’t going to be heard”

Restrictive Intervention Legislation in Tasmania

by

Kristen A. Foss

Submitted in partial fulfilment of the requirements for the Doctor of Health

University of Tasmania July, 2016

Abstract

People living with disability worldwide are still subjected to the use of restrictive interventions. This is in spite of overwhelming evidence regarding the risks of the use of those interventions coupled with an increased rights based approach when supporting people living with disability. Increasingly around the world, policy and legislation is being implemented with the aim of reducing the rates of restrictive intervention in this population. On 1st January 2012 such legislation (*Disability Services Act 2011* (TAS)) was proclaimed in Tasmania.

Drawing on the views of differing members of the Tasmanian disability sector, this thesis sought to determine the success of the implementation of the aspects of the legislation relating to the regulation of restrictive interventions, any perceived barriers to this implementation, and how these might be overcome. I utilised an exploratory research methodology, which included a mixed method of focus groups, interviews and surveys with organisational management, support workers, clinical workers, families and advocates. I conducted a thematic analysis of the data and comparison of results indicated that there are several barriers to the implementation of such legislation in Tasmania. I compared this data with data available regarding the implementation of similar legislation in other jurisdictions.

I found that restrictive interventions are still used within the Tasmanian disability sector. The reasons for this are several-fold. Workers within the sector do not have the skills and training to be able to comply with the legislative requirement to reduce the amount of restrictive interventions used in services. In addition, the attitudes and cultures existing within the sector are not conducive to a reduction in the use of these interventions. The results also revealed that systems of governance are not sufficient to enforce this legislation.

This study provides evidence of the need for cultural change to be addressed, alongside and irrespective of the implementation of the National Disability Insurance Scheme (NDIS). This should include the culture of the support staff, leaders and managers of organisations, board members, as well as clinicians. It is further recommended that a greater emphasis is given to systems of governance, both departmental and organisational. For example, the department should develop a process for penalising non-compliance, and organisational boards should expect greater accountability and reporting around the use of restrictive interventions. This thesis indicates a strong need for additional skill development and training in the areas of positive behaviour support and alternatives to the use of restrictive interventions. Again, this training needs to be directed to organisation and clinical staff. A final recommendation is made in light of the current findings, which is that the Act is operationalised further so that all are definitions, philosophies and roles are clear to all stakeholders.

This thesis provides a platform for considering the national approach to the regulation and monitoring of restrictive interventions in the Tasmanian context, which will be implemented as a result of the introduction of the National Disability Insurance Scheme (NDIS).

Declaration by Author

This thesis contains no material which has been accepted for a degree or diploma by the University of Tasmania or any other institution, and to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due acknowledgment is made in the text of this thesis.

Signed

Kristen Foss

Date 3rd July 2015

Ethical Statement

The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, the guidelines by the Australian Government's office of the Gene Technology Regulatory and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University. Ethics reference number H12443.

Authority of Access

This thesis is not to be made available for loan or copying for two years following the date the statement was signed. Following that time the thesis may be made available for loan and limited copying and communication in accordance with the Copyright Act 1968.

Acknowledgements

My deepest gratitude is to my supervisors, Professors Stella Stevens and James Vickers. I have been so very fortunate to have such patient and insightful academics to guide me. Your academic, professional and personal counsel has enabled my continuous improvement. How fortunate I have been to stumble across two people who are on the same page as me! It has been a privilege to be supervised by you.

To my colleagues, thank you for participating in this research, for invaluable discussion and encouraging me to completion, I am exceptionally grateful. Thank you to organisations and individuals who participated. I trust I have accurately represented your messages.

I am grateful for the love and encouragement from my dear family, Nigel, Will, Hella & Bennie. Thank you for enduring this journey, for your unwavering support, for always being interested, for being exceptionally well organised and accepting. I am proud of the value you place on all people, regardless of difference.

To my generous friend, Nic, thank you for your camaraderie, enthusiasm, distraction and promises of big celebrations!

To my dear Mum, thank you for feeling for me and my juggle to finish this. I hope I graduate so you can be there & I hope somehow, Dad knows I have. It was he who taught me not to accept things I am not satisfied with, to speak up and to have empathy. I will always remember the way he used to emphatically repeat, “You DO know the answer!!!”

My drive to improve the system for people living with disability is borne out of personal experience. (RIP CHDW). I hope this thesis may have some impact on improving the service system and the value placed upon people living with disability. I hope I have heard the screams.

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Keywords

Disability, Restrictive interventions, Restraint, Seclusion, Deinstitutionalisation, Disability Services Act, Senior Practitioner, Behaviours of concern, Challenging behaviour

Glossary

Behaviours of concern: *Those behaviours which indicate a safety and or wellbeing risk to the person or other persons (Chan, 2012)*

Challenging Behaviours: *Behaviours that are culturally abnormal and the physical safety of persons is likely to be in jeopardy. Challenging behaviour also limits a person's access to the community (Emerson, 1995)*

Deinstitutionalisation: *Relocation and integration of people from large institutions to community based living. This is seen as a major step towards social inclusion (Bostock & Gleeson, 2000). A change in living conditions such as this is said to increase a person's quality of life (Lemay, 2009).*

Environmental restrictive intervention: *The modification of an object, or the environment of a person, so as to enable the behaviour control of that person (DSA, 2011).*

Personal restrictive intervention: *Physical contact with a person to enable behaviour control or taking an action that restricts the liberty of movement of the person (DSA, 2011).*

Senior Practitioner (Tas): *Person appointed by the Secretary of Department of Health and Human Services to perform certain functions outlined in the Disability Services Act (2011). These functions primarily relate to advice regarding the provision of specialist disability services and includes the regulation of use of restrictive interventions (DSA, 2011).*

Restrictive Interventions (Tas): *An action taken to restrict the rights or freedom of movement of a person with the primary purpose of behaviour control (DSA, 2011).*

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List of abbreviations used in the study

DHHS	Department of Health & Human Services
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
CRPD	United Nations Convention on the Rights of Persons with Disabilities
DAAT	Disability Assessment & Advisory Team
CEO	Chief Executive Officer
OSP	Office of Senior Practitioner
APRAIS	The Alliance to Prevent Restraint, Aversive Interventions and Seclusion
COAG	Council of Australian Governments
DPRWG	Disability Policy and Research Working Group
BSP	Behaviour Support Plan
RIDS	Restrictive Intervention Data System

Chapter 1.

Setting the context

Chapter 1. Setting the Context

Introduction

In 2009, it was estimated that 2.7% of the population of Tasmania had a disability. This is the highest rate in Australia (ABS, 2009). The primary target group for specialist disability services is the 22,000 Tasmanians under the age of 65 that have a severe or profound disability. In the years 2013/2014, there were 6547 users of funded disability services in Tasmania (NMDS, 2015).

The *Disability Services Act 2011* (Tas)(the Act)(see appendix I) provides the new legislative framework for disability service provision in Tasmania. The Act serves to define disability and eligibility for specialist disability services. Specialist disability services are defined as those “...services specifically for or related to the support of persons with disability and includes, but is not limited to including the following:

- (a) Accommodation support Services;
- (b) Home care and family support services;
- (c) In-home community based services;
- (d) Intake and assessment services;
- (e) Independent living training services;
- (f) Information services and print disability services;
- (g) Recreation services;
- (h) Respite care services;
- (i) Education or training services;
- (j) Counselling, support or advocacy services;
- (k) Community visitor services;
- (l) Therapy services;
- (m) Equipment services;
- (n) Transport services;
- (o) Intermediary services

But does not include prescribed services” (*Disability Services Act 2011* (Tas)). (Part 1, Section 4).

Behaviours of concern are prevalent amongst people with disabilities (Xeniditis, Russell & Murphy, 2001). The management of such behaviours requires a specific set of skills and expertise in order to be most effective. A small proportion of people who exhibit behaviours of concern may be at risk of harming themselves or others, and a restrictive intervention might be used in order to prevent or minimise this harm. Restrictive interventions are also used in other circumstances related to skills deficits in people being supported, for example safety in traffic, or in the community generally.

Part 6 of the Act allows for the regulation of restrictive interventions. Within the Tasmanian disability services context, a restrictive intervention is defined as “...any action that is taken to restrict the rights or freedom of movement of a person with disability for the primary purpose of the behavioural control of the person...” (*Disability Services Act 2011* (Tas)) (Part 1, Section 4).

The risks of the use of restraint are well documented. These risks are identified as being the risk of physical harm (Wilkins, 2012; Weiss, 1998), psychological harm (Ramcharan, Nankervis, Strong, & Robertson, 2009), consequences to dignity (Wilkins, 2012), cost to organisations (Chan, Lebel, & Webber, 2012), staff injury (Stewart, Bowers, Simpson, Ryan, & Tziggili, 2009) and prolonged recovery (Substance Abuse and Mental Health Services, 2005).

Australia became a signatory to the United Nations Convention on the Rights of Persons with Disabilities in 2008 (CRPD). The Convention specifically prohibits discrimination against people with disability, in all areas of life. ‘People with Disability Australia’ is also leading a delegation to participate in the United Nations Convention against Torture (PWD, 2015). This is to ratify the convention against torture and other cruel, inhumane or degrading treatment or punishment. The use of restrictive interventions may fall under these categories. One source of motivation to amend the previous Disability Services Act (*Disability Services Act 1992* (Tas)) was Australia becoming a signatory to the Convention.

Throughout history, people with disability have been seen as requiring protection from society and, evoke feelings of sympathy rather than respect (United Nations, 2006). The CRPD is a treaty designed to change this perception and ensure that society recognises that people with a disability must be provided with the same opportunities as any other person.

The prevalence of the use of restraint in Tasmania has not been formally quantified. An audit was conducted of all homes in the Southern region, by Department of Health and Human Services (DHHS) in 2005. This audit revealed that four group homes regularly used restrictive practices. As at March 2015, there are 144 group homes in Tasmania. In addition, the disability service system operates respite centres and individualised support for housing and community access. In 2005, the regulating body for the use of restrictive interventions was the Disability Services Ethics Committee. However, the definitions of restrictive intervention were unclear, and varied from those outlined in the current Act. The role of this committee also varied from the regulatory role outlined in the new Act. No monitoring or service system improvements were required of this committee, unlike those required of the Senior Practitioner role defined in the Act.

In Tasmania, as in Victoria, a “Senior Practitioner” is responsible for monitoring the use of restrictive interventions and is charged with the power to investigate services for the use of such

interventions (*Disability Services Act 2011* (Tas), *Disability Act 2006* (Vic)). Under *the Disability Act 2006* (Vic), a position of Senior Practitioner was established to help protect the rights of people with a disability who may experience restrictive interventions by disability services funded services. The position of Senior Practitioner was implemented in Tasmania in 2012.

The Act outlines the roles and responsibilities of this new position of Senior Practitioner- which are intimately related to the management of behaviours of concern. These roles and responsibilities include providing advice to the department's Secretary in relation to the provision of specialist disability services; to make recommendations to the Secretary as to how the provision of specialist disability services may be improved; and any other functions under the Act. A large component of this role is the regulation of restrictive interventions that might be used in specialist disability services. The Senior Practitioner is required to develop guidelines and standards that are in accordance with best practice in relation to restrictive interventions. This includes the provision of education and information about restrictive interventions, as well as the use of behaviour management techniques that may obviate or minimise the need for the use of such interventions; to undertake research in relation to the use of restrictive interventions; and to provide information about the rights of persons with disability who may be subject to restrictive interventions. The use of restrictive interventions within disability services may lead to civil penalties or may even constitute a criminal offence. I have been appointed to the role of Senior Practitioner.

The service system in Tasmania, and Australia wide, is set to change in 2016 with the introduction of the National Disability Insurance Scheme (NDIS). The NDIS commenced on 1 July 2013 as a trial, and it significantly changes the way that disability support is funded and accessed. From 1 July 2013, the NDIS began in Tasmania for young people aged between 15-24. In South Australia the trial cohort involves children aged between 0-14. In Victoria and New South Wales (NSW) the trial involves people up to age 64. In July 2014 the trial continued in the Australian Capital Territory (ACT), Northern Territory, and Western Australia. The roll out of the full scheme in NSW, Victoria, Queensland, South Australia, Tasmania, the ACT and the Northern Territory will commence progressively from July 2016.

NDIS is essentially a new way of funding support that is individualised. This will enable people with disability to have greater choice and control with a lifetime focus on their support needs. People with disability will have greater choice and control in their lives through a person-centred, self-directed approach to service delivery with individualised funding-rather than a system based on available supports with little flexibility for individual choice and tailoring.

As an integral part of the NDIS, a quality assurance system will be implemented and will include oversight responsibilities of and reporting on the use of restrictive interventions by services supporting NDIS participants. NDIS, in consultation with states and territories, have developed a

National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Service Sector (The National Framework). This National Framework is consistent with the requirements contained within the Act in terms of philosophy and intention. That is, strategies are required to guide the reduction of the use of restrictive practices in the disability service sector. Based on my observations from professional practice, there is significant assessment and work the Tasmanian service system needs to implement in preparation for the implementation of the National Framework.

Aims of study

The introduction of the *Disability Services Act 2011* (Tas) provided a framework for regulating the use of restrictive interventions in relation to persons with disability. This Act brings about a renewed focus on practices which are consistent with the principles of the CRPD.

The Act led to the need for a service system change which requires associated and ongoing education, support and monitoring of care workers' knowledge of the changes. Due to changes in the Act subsequent to the signing of the CRPD, new philosophies and spirits were built into the Act which necessitated changes in the manner in which disability services supported people. For example, there is now a requirement for monitoring the use of restrictive interventions in the *Disability Services Act* (2011) that was absent in the *Disability Services Act* (1992).

In order to provide the most effective assistance for the sector, an understanding of current practices is required. This includes a need for reliable data about the incidence of restrictive practices in Tasmania. This study seeks to understand the the existence of the use of restrictive interventions in the sector as well as activities conducted by organisations, including training which may be designed to help reduce the use of restrictive interventions in services. If it is determined the use of restrictive interventions is common in the sector, an understanding of the reasons for this will be vital in reducing their use. A jurisdictional comparison will also be useful to determine if there are any lessons to be learned from the experience of others and will also help in the development of recommendations as to how to overcome identified barriers.

An intended outcome of this study is to help identify the critical issues which may be faced by those attempting to implement the NDIS system in Tasmania, ready for the full roll out of the national scheme in 2019. New standards are to be implemented as part of this system. Tasmania's readiness to address the issue of minimising the use of restrictive interventions will be crucial to the successful implementation of this new service system.

In summary, the primary aim of this study is to examine whether or not restrictive interventions are used, as defined under the *Disability Services Act 2011* (Tas), within disability service organisations. This provides an indication of the extent to which the relevant aspects of the

Act have been implemented. If it is determined restrictive interventions are used within the sector, the second aim will be to gather information about barriers to the implementation of those sections of the Act which relate to the use of personal and environmental restrictive interventions. This information will assist in making recommendations for the development of the service system in line with legislative requirements.

Overview of the study

This current chapter establishes the overall context of this study by outlining the importance of establishing a sense of Tasmania's current practices, Tasmania's readiness for their new legislation and the subsequent implementations brought about by the new service system structure of NDIS. The service system is currently in a state of flux, being required to prepare for major changes at the same time as implement new legislation. The practice frameworks required in the new legislation will also be required in the new NDIS structure. It is therefore timely to identify those issues now.

Chapter 2 presents the study's literature review. This review explores the issues in greater detail, along with a description of the evolution of the Tasmanian service system and how restrictive interventions are defined in Tasmania. The evidence base for the address of behaviours of concern is examined in addition to the social context of these behaviours. In addition, the situations in other jurisdictions are examined, including where possible, the prevalence of use of restrictive interventions.

This chapter explores the risks of the use of restrictive interventions as well as the factors which increase the probability of restrictive interventions being used. Impending changes to the Tasmanian system are also defined and the relevance of this study in the context of these changes discussed.

In terms of the approach to addressing these areas and questions, exploratory research is a useful methodology when the aim is to improve the understanding of professional practice through continuous learning and problem solving (Riel, 2010). Given that one of the aims of this project was to understand Tasmania's readiness to address the issue of the reduction of use of restrictive interventions and to assist in this reduction, this research methodology is appropriate. I have conducted research as a relative insider to the sector. Chapter 3 provides a detailed outline of the methodology of this progressive inquiry study including target populations, participant numbers, participant recruitment methods, data collection methods and data analysis procedures. This chapter outlines the way the methodology evolved throughout the course of the study, as a result of the fact the research was completed during my professional practice in the role of Senior Practitioner. Finally, this chapter considers methodological considerations and research ethics.

The results and evaluation have been combined in Chapter 4 in order to consider issues raised from earlier chapters. The process of exploratory research did not lend itself to a neat delineation of events that could be separated in a traditional results/conclusion manner. This chapter primarily draws upon a thematic analysis approach to consider the issues identified as barriers to the implementation of the Act. The issues identified are outlined in this chapter and are as follows:

- How much restrictive interventions are used
- Managers and Leaders of organisations
- Governance
- Education and Training
- Consistency of support
- Attitudes

Chapter 5 revisits the core themes identified in the literature review against the findings of the study and the current situation in Tasmania. Conclusions are drawn, namely that the Act is not fully implemented in the state. This chapter will identify the main overarching issues preventing the full implementation of the Act in Tasmania, as well as the potential for future reduction of use of restrictive interventions. The main themes identified and therefore discussed in this chapter are:

- The impact of legislation on practice change
- The low priority that Act implementation is given in Tasmania
- The influence of culture and attitudes upon Act implementation
- The sufficiency of the legislation
- The impact training and education in the sector has upon the ability of the sector to implement the changes required in order to implement the Act.

The final chapter details conclusions drawn from this study and identifies further areas of research that have emerged as a result of the findings.

Chapter 2 presents the context for the current study through an examination of current literature. This literature demonstrates that best practice in the management of behaviours of concerns does not include the use of restrictive interventions. The literature also underlines recent legislative changes to reflect this. The review emphasises the recent changes in Tasmania, in order to set the scene for the assessment of the efficacy of the implementation of these changes. That is, Tasmania's readiness to implement changes designed to reduce the use of restrictive interventions in the sector.

Chapter 2.

Literature Review

Review of the Literature

Introduction

The service system to support people living with disability is changing nationally, and this includes major changes for the state of Tasmania. Consistent with these changes, it is necessary to support people from a human rights perspective. The use of restrictive interventions necessarily impinges on human rights and is therefore inconsistent with the human rights perspective, except in circumstances of danger and as last resort, for example. The purpose of this current chapter is to provide a rationale for the current study through an examination of relevant literature. This literature review is divided into several sections: an examination of the changing nature of support generally; the nature of current support systems in Tasmania; the legislative and contextual background to this issue; under which circumstances are restrictive interventions are more likely to be used; the risks associated with the use of restrictive interventions; the prevalence of their use; their prevalence of use in other jurisdictions; and a comparison of jurisdictions and the factors affecting the use of restrictive interventions. Finally, this chapter concludes with the outline of the relevance of this information to Tasmania.

The term ‘restrictive practices’ is used in behavioural fields to refer to practices which limit a person’s movement, access to their personal possessions, or that otherwise restrict their liberties (Sturmey, 2009). It is claimed these interventions are sometimes required due to the existence of ‘challenging behaviours’ in people with disability, particularly intellectual disability (Matson & Boisjoli, 2009; Emerson, 2001; Harris, 1996). These interventions may be planned or unplanned, and implemented in some cases by staff or parents with little training (Matson & Boisjoli, 2009).

Challenging behaviour/behaviour of concern terminology

The term ‘challenging behaviour’ is a social construct (Emerson, 1998), as varying behaviours will have differing consequences for the individual and those around them. The term challenging behaviour does not refer to a single topography or description of behaviour for this reason. LaVigna and Willis (1995) highlight challenging behaviour remains one of the main barriers to social integration between the general population and those living with disability. These barriers may include both the behaviour challenges the person presents, as well as the support strategies that have traditionally been employed to remediate these challenges. Instead, the term challenging behaviour defines behaviours that are: “...viewed as culturally abnormal and are of such intensity, frequency, and duration that the physical safety of the person or others is likely to be placed in serious

jeopardy, or behaviour which is likely to seriously limit use of or deny access to ordinary community facilities” (Emerson, 1995, p4-5).

In the UK, 15 adults per 100 000 of the general population have an intellectual disability and exhibit challenging behaviour (Emerson, 2001; Broadhurst & Mansell, 2007). Kiernan and Kiernan (1994) found prevalence rates of 2% for extremely difficult and 14% for moderately difficult behaviour in children with a severe learning disability. Hogge, Lambe, Crowie, and Coxon (1987) found the prevalence of sexually inappropriate behaviour in children with learning disabilities was 6%, and those who made disruptive sounds and noises 43%. Through direct interviews with primary carers of services for people with disability across seven unitary authorities in the UK, Lowe, Allen, Jones, Brophy, Moore, and James (2007) found that 10% of the population of people with disabilities were rated as seriously challenging, with the most prevalent form being disruptive behaviour, and non-compliance being the most prevalent type of behaviour. The most challenging behaviours were those which came from more than one behavioural category. Supporting the person exhibiting these behaviours can be extremely difficult.

The challenging behaviour term was deemed as innovative in the mid to late 1990’s as it emphasised the social context of behaviour. This was an alternative to perceiving behaviours as the fault of the person exhibiting them, and instead attributing a communicative intent in the context of disability. This communicative intent is determined through a functional analysis. Functional analysis is often used when addressing challenging behaviours - forensic or otherwise - within Australia (Doyle, 2004). A functional analysis involves the identification of variables that might influence the occurrences of behaviours of concern (Hanley, Iwata, & McCord, 2003) and involves the testing of hypotheses about the function of these behaviours (Rispoli, Ninci, Neely, & Zaini, 2013). It is assumed that this behaviour does not occur in a vacuum, and understanding it involves determination of the context of the behaviour (LaVigna & Donnellan, 1986). A functional analysis is an examination of the behaviour to determine the communicative function of that behaviour. Strategies to address this function, and replace the behaviour of concern, are typically compiled in a behaviour support plan (BSP) for workers to follow. Some Australian legislation (for example *Disability Services Act 2006* (Vic)) requires any restrictive interventions to be written up in such support plans.

In his 2012 paper, Chan (2012) suggests a terminology change to “behaviours of concern”. The rationale for this being the change in how disability is perceived. Chan outlines that if the causes of challenging behaviours are seen to exist within the people who exhibit them, people may view the person as being challenging rather than their behaviours as challenging. ‘Concern’ evokes a feeling of compassion rather than ‘challenging’ which evokes feelings of readiness to contest or fight. Chan argues the CRPD states disability results from the interaction between people with impairments

and their environment- including attitudes. Barriers developed through these interactions hinder equal participation in society.

The term, “Challenging behaviour” may be more appropriately used to refer to those behaviours that challenge workers. Examples from my own professional experience include frequent questioning, loud vocalisations, and so on. These behaviours do not necessarily need to change, but require workers’ perceptions and reactions towards them to change. The term “behaviours of concern” would be used to define those behaviours that indicate a risk to the safety and well-being of the person exhibiting them or of others. This provides another example of the changing context of disability and the service system approach to disability which is more consistent with a philosophy of human rights, acceptance, and inclusion.

Models of support

Traditionally, differing models of disability have been used to help explain the restrictions experienced by people living with disability. The medical model, sometimes referred to as an individual model due to its focus on the individual, views disability in terms of an individual difference- deficit or lack thereof (Rothman, 2010). The management of disability in this model relies on medical doctors as the experts to help manage the disability. Dickson (2007) argues that this model is associated with ‘charity’ (p 64) rather than rights based approach to access and integration.

In contrast, the social model of disability sees the source of disability as a failure in society (Dickson, 2007). An increase in the acceptance of the social model of disability helps to see disability and challenging behaviour as a result of environmental and social factors rather than some deviance in the body of the person. Historically, disability has been seen as “...morally objectionable or contrary to the natural nature of existence” (Mackelprang & Salsgiver, 2009, p 24). Mackelprang and Salsgiver outline the transformation of disability being perceived as something pathological, to a more scientific perspective. That is, disability could and should be treated or cured through science. It was not until the second half of the twentieth century that disability began to be redefined in the social context of a disability rights movement. “A new disability identity and culture are gradually gaining recognition” (Mackelprang & Salsgiver, 2009, p 24). This shift emphasises that people with disability deserve to enjoy the same rights, risks and responsibilities as those without disability. The use of restrictive interventions deny a person their deserved rights as they potentially hinder access to all aspects of a person’s environment- including belongings, the freedom to move about freely, risks and responsibilities and so on. The use of a restrictive intervention may indicate someone else has decided this “punishment” is warranted. This tends to deny that the behaviour is a construct created by communication, attitudinal, and environmental factors.

Recently, the use of restrictive interventions has come under much closer scrutiny than in the past. This is due to this increasing awareness of the human rights of people with disabilities and questions about the efficacy and ethics of such interventions (Mohr, 2010). Accordingly, it is necessary that services and treatment are subjected to explicit human rights related ethical and legal considerations and to principles of human rights (French, Chan & Carracher, 2010).

There has also been a change in the service system, with a move to smaller residential placements rather than large institutions. This change is an indication of policy revision and is consistent with the changing model of disability. Greater community access and integration for people with disabilities indicates a move towards the philosophy of equal opportunities for all, including those with disability.

The use of restrictive intervention does not fit with a model that views behaviours of concern as a mismatch between the environment and skills of a person. It is only very recently that the scrutiny of restrictive practices has been included in Australian legislation (Romijn & Frederiks, 2012). There has been a paucity of studies examining the use of restraint practices within disability service providers (Jones, Allen, Moore, Philips, & Lowe, 2007). Consequently, we have very little evidence to inform the development of policy (Webber, McVilly, Stevenson, & Chan, 2010) and any changes required for the disability service system. Evidence is, however, starting to emerge. This evidence will be reviewed in the literature review.

This review of literature will examine the extent to which restrictive interventions are used in other jurisdictions, and in Tasmania more specifically. In this literature review, I will examine the intent of Tasmania's new disability services legislation. In addition, I will examine the service system developments required to help reduce or eliminate the use of restrictive interventions. This thesis will also review literature examining why it is preferable to avoid the use of restrictive interventions and to help identify alternatives to the use of restrictive interventions.

Changing nature of disability support in Australia

Deinstitutionalisation

“Here and there scattered over the country, may be villages of the simple, made up of the warped, twisted and incorrigible, happily contributing to their own and the support of those more lowly-cities of refuge in truth havens in which all shall live contentedly, no longer misunderstood nor taxed with attractions beyond their mental or moral capacity” (Kerlin, 1885 as cited in White & Wolfensberger, 1967, P.7)

Over the last 30 years or so, there has been significant change in the provision of residential services for people with disabilities (Young, Ashman, Sigafos, & Grevell, 2001).

Deinstitutionalisation is the policy approach in many countries, including Australia. Australia is experiencing a trend to decrease institutional beds (Lemay 2009). In 2004-2005, 5000 Australians remained institutionalised – this could be considered the most segregated form of service provision (Stancliffe, 2012). Deinstitutionalisation began in Australia in the 1970's and refers to the large scale restructure –for example, the closure or downsizing of institutions and their replacement with community care homes (Chenoweth, 2000). That is, to include the relocation and integration of people into their communities. Deinstitutionalisation is a major step towards the social inclusion of people living with disability (Bostock & Gleeson, 2000). This led to the redesign of services, predominantly to using community based group homes.

This is consistent with service system changes in other countries. For example, in the USA, deinstitutionalisation has emerged from several principles: that people with disability have a legal right to live in the community and receive necessary supports; and life in the community should provide opportunities for dignity, freedom, choice and a sense of belonging that are not possible in an institutional environment (National Council on Disability, 2012). Accordingly, the *Americans with Disabilities Act* (ADA) upholds a person's right to receive services in the least restrictive environment possible. As of 2009, nearly thirty four thousand Americans remained in institutions. Over the past forty years more than 230, 000 have been discharged into the community (National Council on Disability, 2012).

Deinstitutionalisation in Australia involved major changes in the types of places where people with disabilities reside, as well as the size of the housing. There is a considerable body of research examining the controversial topic and the risks and benefits associated with leaving institutions (Kim, Larson, & Lakin, 2001). Some research indicating the move away from institutions benefits those with disability; other research indicates those movement have not necessarily led to overall benefits (Beadle-Brown, Mansell, & Kozma, 2007; Lemay, 2009).

Deinstitutionalisation is said to increase the quality of a person's life and encourage improvements in adaptive behaviours (Lemay, 2009). A New Zealand study investigated the outcomes of 61 people with intellectual disabilities moving into community housing from a psychiatric hospital. The participants were able to communicate themselves about the extent to which they had become involved in the community since leaving the institution. Their families and staff were also included in the study. Overall, the participants regarded their move as positive. They reported improvements in daily living skills, social skills, and quality of life (O'Brien, Thesing, & Tuck, 2001).

However, in a 12 year follow up study examining people with intellectual disability who have resettled from long stay hospitals, Forrester-Jones and colleagues (2006) found that community care

has not generally resulted in their social inclusion. The majority remain in small, high density networks which mainly comprise people connected to disability services.

It does not follow that moving those living with disability into communities will automatically lead to an increase in quality of life- this is particularly so for those with challenging behaviours (Beadle-Brown, Mansell, & Kozma, 2007). Deinstitutionalisation may in fact lead to an increase in challenging behaviours (Lemay, 2009) and therefore it follows there may be concern around the strategies used to manage these behaviours. Increasingly, efforts are concentrated on positive behaviour supports to help address challenging behaviour; however, in community and clinical settings, restraint is still commonly used (Matson & Boisjoli, 2009). The use of restrictive interventions in order to manage behaviours of concern possibly compromises the quality of life of an individual living in the community.

The move towards community care requires a huge restructure of services and a shift in carer ideology, from paternalistic over-control, to an approach that strikes a balance between under- and over-control (Crichton, 1998). Support and advocacy for people with disability often now falls to people who are untrained and unprofessional (Bigby & Atkinson, 2010). The result of replacing institutionalisation with community based services will be the emergence of a rights based model of disability. This offers the potential to remove some of the more negative features of other models, such as waiting lists, minimum standards approaches, and out of area placements (Mansell, 2006). This will be particularly relevant in Tasmania due to the implementation of the National Disability Insurance Scheme (NDIS).

National Disability Insurance Scheme

In the 2013-14 Budget, the Australian Federal Government committed to provide \$19.3 billion over seven years from 2012-13 to roll out NDIS across ninety per cent of Australia. The scheme will be fully rolled out by July 2019. At that time it will provide support for approximately 460, 000 people living with disability in Australia. The scheme will re-orient funding and the provision of services so that those being supported can have choice and control over the type of service they want, and the goals they wish to achieve. Life control and choice are concepts consistent with the CRPD (NDIS, 2013). It may be the case that there will be more of a balance between carer control and choice. It seems likely that NDIS will support an inclusive society- thus increasing a person's networks beyond those simply centred around and associated with disability. Participants of NDIS should be able to access a full range of products, services, environments, and communities on an equal basis with other citizens (NDIS, 2013). NDIS claims to be a person centred approach.

As a signatory to the CRPD, Australia has a responsibility to operate from such a rights-based approach. This includes reducing and eliminating the use of restrictive practices to maintain consistency with these principles of rights, freedom, and dignity.

Nature of disability support in Tasmania

In a 2009 Joint Standing Committee on Community Development held in Hobart, the then Deputy Secretary of Health and Human services was called to provide evidence about those aspects of the old *Disability Services Act 1992* (Tas) that were under scrutiny. The following formed part of her evidence.

“There should be a greater emphasis on inclusion. The mode of disability services which we are actually working towards implementing is one that is really making maximum use of the mainstream services which are already available in the community, rather than setting up specialist services that only exist for people with disabilities, recognising that they will always be needed for a small number of people. We ought to really be trying to make sure that people with disabilities are able to participate in the mainstream recreation services, mainstream art service, mainstream education and whatever else, rather than always having specialist things. So that is why we are talking about inclusion there.” (Alison Jacob, 2009, p5)

“...I worked at Willow Court for 3 1/2 years. I know what happens when you isolate people with disabilities in what is basically an inhumane way...” (Alison Jacob, 2009, p6)

The nature of disability support in Tasmania was changing. Willow Court, Tasmania’s largest institution for those with disability was closed in 2000. This was in recognition that institutionalising people living with disability was not appropriate. Deinstitutionalisation in Tasmania commenced around 1993, with the aim being community integration. Ratcliff and Kirby (2002) question whether the closure of Willow court represents “...a triumph of ideology and cost cutting, or a casting off of outmoded and at times damaging models of care” (p132). There was no national framework for the closing of institutions, however in Tasmania this was facilitated through policy change and the introduction of the Act.

In 2010, a review of this legislation began. The objective was to review the Act to ensure that it reflected contemporary practice in the provision of services to people with a disability. People living with disability are predominantly living within community settings, and legislation change was required to reflect this and the rights of those living with disability in Tasmania.

Legislative & policy background for disability support in Tasmania

This section outlines the legislation and associated strategies which have influenced the direction of the disability sector in Tasmania. The overarching legislative context for disability

services is provided through the *Disability Services Act 1986* (Cwlth). The objectives of this Act include to:

- (1) Assist persons with disabilities to integrate into the community and complement services available generally to persons in the community
- (2) Assist persons with disabilities to achieve positive outcomes such as increased independence, employment opportunities and integration into the community.

Since the development of this legislation, a review of a national survey and users of services in Australia shows that significant progress has been made in the area of integration for people living with disability, however there continues to be a heavy reliance on segregated services (Stancliffe, 2012). Stancliffe notes that users of Australian disability services are more likely to experience greater inclusion if they live in less segregated settings. Transport is obviously a key to inclusion. He also notes that progress has been made with transport accessibility. It is difficult to accurately measure the inclusion experienced by disability service users, as this information is not routinely collected by disability services in Australia. This should be included in the federally collected data collected in the future (Stancliffe 2012). As Stancliffe outlines, the Commonwealth State/Territory Disability Agreement (CSTDA) means that since the early 1990's the commonwealth administers funding for employment services, while states and territories administer funding for accommodation support and most other services. Subsequently, states were required to pass their own disability legislation. Hence, in Tasmania the *Disability Services Act 1992* was passed.

In November 2008, a National Disability Agreement was signed by the Council of Australian Governments (COAG). This agreement commits the Commonwealth, state, and territory governments to assist people with disabilities achieve inclusion, enjoy choice, well-being and the opportunity to live as independently as possible and to support their families and carers.

In 2009, the National Disability Strategy 2010-2020 was developed in order to operationalise Australia's commitment to the CRPD. Consultation around this strategy suggested that, even then, there was significant disadvantage and discrimination experienced by people with disabilities (National People with Disabilities and Carer Council, 2009). This strategy is designed to play a role in "...protecting, promoting and fulfilling the human rights of people with disability...leadership for a community wide shift in attitudes to look beyond the disability" (p 9).

The Tasmanian State Government is attempting to address the issues of equality and inclusion in Tasmania. This involves a 20 year social, environmental, and economic plan: "Tasmania Together". Launched in 2001, this plan aspires to promote participation and equal access for all Tasmanians. This, combined with the Tasmanian Disability Framework for Action (2013-2017), provides whole of government policy to remove barriers and enable people with disabilities to have

the same rights and opportunities as all other Tasmanians (Disability Framework for Action, 2012).

In addition, Professor David Adams (2009) released a social inclusion strategy for Tasmania. This summarised research relevant to Tasmania about social inclusion and provided a series of recommendations aimed to help Tasmania towards a position of greater social inclusion. Adams identifies those living with disability as being at risk of social exclusion. The development of the new Act required consideration of such principles of inclusion.

Disability Services Act 2011 (Tas)

The Act outlines relevant principles in relation to restrictive interventions, as well as the human rights of people with disability:

- The needs and best interests of persons with disability are to be promoted and, as far as practicable, decisions or actions that may directly affect a person with disability should only be taken after the person has been consulted and their wishes have been taken into account (section 5 (2) (a) and (b)).
- Relevant activities and decisions taken by service providers should only result in the restriction of the freedom of decision and action of the person, if at all, to the smallest extent that is practicable in the circumstances (section 5 (2) (b) (iii)).

Thus, a major intention of the Act is to monitor and review any use of restrictive intervention within the sector. This Act identifies and defines “personal” and “environmental” restrictions. Personal restrictions, in relation to a person with a disability, means a restrictive intervention that relates to that person that consists wholly or partially of “(a) physical contact with the person so as to enable the behavioural control of the person; or (b) the taking of an action that restricts the liberty of movement of the person”. This definition includes practices such as the use of mechanical restraint, belts, vests, helmets for example. This definition also includes practices such as containment (preventing free exit) and seclusion (confining a person alone) as well as physical restraint as described below.

This is distinct from an environmental restriction which is defined as “...the modification of an object, or the environment of the person, so as to enable the behavioural control of the person but does not include a personal restriction” (*Disability Services Act 2011* (Tas), Section 4.4). By way of explanation, this definition includes practices such as preventing a person’s access to their own wardrobe, bolting a chair to the floor or turning off hot water to prevent a person from showering.

Agreement around definitions nationally will be required in light of the NDIS. The Disability Policy and Research Working Group (DPRWG) is working on agreement regarding the meaning and application of overarching definitions. All Australian jurisdictions are in the process of developing either operational policy or legislation to monitor the use of restrictive interventions, with a view to

obviating the need for their use. Currently, there are four jurisdictions with legislation governing the use of restrictive interventions relating to people living with disability. These are Victoria, Queensland, Northern Territory, and Tasmania. All jurisdictions contain different methods of regulation, differing definitions and processes. These differences across jurisdictions may lead to significant challenges when attempting to implement one nationally consistent system.

The definitions used in the National Framework fall into five categories: seclusion; chemical restraint; mechanical restraint; physical restraint and other. The proposed definitions are as follows:

Seclusion refers to the sole confinement of a person with disability in a room of physical space at any hour of the day or night where voluntary exit is prevented.

Chemical restraint does not include the prescribing of medication for the treatment of a diagnosed condition. It is a term used to describe the using of a chemical substance in order to control behaviour.

Mechanical restraint means the use of a device (not for therapeutic purposes) to prevent, restrict, or subdue a person's movement or control a person's behaviour.

Physical restraint is the use or action of physical force to prevent, restrict, or subdue movement for the purpose of controlling behaviour.

The category of other includes environmental, as per the Act, as well as other interventions such as psychosocial restraints or those consequence driven practices

The issue of defining 'personal' and 'environmental' interventions currently causes some operational issues in Tasmania. These definitions differ from those used in other jurisdictions, and it is therefore difficult to take the lead from these. Some environmental modifications may restrict the liberty of movement of a person, such as locking doors; it is therefore unclear which category such an action may fall under. This has implications for comparisons across jurisdictions, as well as the approval processes which need to occur. It is perhaps relevant to note that chemical restraint is considered in the context of this study as it is not included in the DSA. In Tasmania, chemical restraint is regulated through the *Guardianship and Administration Act 1995* (Tas).

Rickard, Chan, and Merriman (2013) examined the development and implementation of legislation designed to address the issue of restraint use in Victoria and Ireland. Through this process, they identify some issues with policy implementation. One of these is confusion around definitions. They conclude that mandating the reduction in use of restrictive interventions may not be sufficient to ensure this reduction actually occurs, because of the difficulty of defining what is and is not a restriction. Leadbetter and Paterson (2009) as cited in Rickard and colleagues (2013) state that this is because there are organisation barriers, such as occupational health and safety implications,

recruitment, training development of staff, and difficulties in accessing specialist staff, all of which work to hinder the reduction of restraint, even in the context of legislation that speaks to this issue.

Following the implementation of legislation to reduce the use of restrictive interventions in Norway, Sondenaar, Dragsten & Whittington (2015) examine the reasons for the paradoxical increase in the use of restrictive interventions. The researchers conclude the reasons for this was related to increased awareness brought about by the legislation.

Clarification of definitions outlined in the legislation becomes important in Tasmania as this helps to dictate the approval pathway for a proposed intervention. That is, the DHHS have the capacity to approve those interventions defined as ‘environmental’. The Guardianship and Administration Board may approve both personal and environmental restrictive interventions, following recommendation from the Senior Practitioner. If this is not recommended, the approval process is not progressed. Clarification of definitions helps people to determine the impact that such a restriction may have upon a person’s quality of life and integration. Operationalisation of definitions therefore becomes vital.

Risk of use of restrictive interventions

A range of risks following use of restrictive interventions have been identified and are now generally accepted. The Alliance to Prevent Restraint, Aversive Interventions and Seclusion (APRAIS) comprises members of leading American disability advocacy organisations, and was established in 2004. With a strong focus on eliminating the use of restrictive interventions, they emphasise the adverse outcomes of restriction stating that it:

- “Causes serious physical and psychological harm,
- Results in the dehumanization of all involved,
- Prevents the development of respectful and supportive relationships between children and adults, and
- Leads to the segregation and exclusion of children from their communities” (APRAIS, 2012, para 5).

Some consider the use of restraint is at times required, usually as a last resort (Luiselli, Sperry, & Magee, 2011; Luiselli, 2009) and under certain circumstances, for example preventing acts of physical violence or severe self-injurious behaviours (Perry, White, Norman, Marston, & Auchoybur, 2006; Sequeira & Halstead, 2001). This is acknowledged in the mental health sector. That is, there are situations where it is appropriate to use interventions such as restraint and/or seclusion, but only as a safety measure of last resort (Australian Department of Health and Ageing, 2005). Similarly in other jurisdictions, for example South Africa, practices such as seclusion are only

to be used to contain severely disturbed behaviour that is likely to cause harm, and when other treatment techniques have not worked (Luckhoff, Jordaan, Swaart, Cloete, Koen, & Niehaus, 2012).

APRAIS considers seclusion and aversive interventions to be unjustifiable under any circumstances (APRAIS, 2012). Others suggest it is commonly accepted restrictive interventions should not be used unless there is no less restrictive alternative (Spivakovsky, 2012).

Patient safety is a main factor of concern in the use of such interventions (Department of Health, 2008). There is a clear relationship between the use of restrictive interventions and adverse outcomes (Australian Department of Health and Ageing, 2005). Restrictive interventions can be physically harmful or cause death (Wilkins, 2012). Weiss (1998), in the US, reported one hundred and forty two deaths had occurred due to restraint related issues in group homes, prisons, and institutional settings. In the UK during the 1980's -1990's due to associated risks, there was widespread campaigning to improve the policies, training, and application of physical techniques (Deveau & McDonnell, 2009).

Inquiries into sudden deaths during instances of physical restraint indicate that cardiac arrhythmias are often the final cause of death (Mohr, Pette, & Mohr, 2003). Whilst there is no central repository for collecting data regarding restraint related deaths, a literature review conducted by Paterson, Bradley, Stark, Saddler, Leadbetter and Allen (2003) identified a cluster of deaths: neck holds (for example pressure on carotid arteries); mechanical restraint related deaths (for example being hanged by the restraint failing); prone restraint related deaths (for example affecting respiration); atypical restraint related deaths (for example again compromising respiration). Inquiries into restraint related deaths suggest that people with learning disabilities may be particularly vulnerable to negative consequences as a result of being restrained (Perry et al., 2006). They provide many examples of this, including: persons who are significantly overweight should not be restrained on the floor unless with extreme caution, due to hampering of air into the lungs. Obesity is particularly prevalent amongst those with learning disabilities (Emerson, 2005 as cited in Perry et al., 2006), thus increasing their risk of severe harm if subjected to such restraint.

Non-lethal issues may also result from restrictive interventions, for example staff injuries. Injury to staff was identified as an outcome of the use of manual restraint in psychiatric care (Stewart, Bowers, Simpson, Ryan, & Tziffili, 2009). Client and staff safety issues are closely associated with the use of restraint (Sturmey, 2009). For example, Powell, Caan, and Crowe (1994) found that manual restraint can sometimes provoke aggression, and thus carries the risk of injury for staff and patients. Both clients and those using restraint may feel negative consequences such as feeling physically exhausted, anxious and insecure (Heyvaert, Saenen, Maes & Onghena, 2014).

Further impact on staff

The use of restraint may also have a further negative impact on staff. Bethel and Beail (2013) argue that the use of mechanical restraint has a negative emotional impact upon staff. When interviewed, one staff member reported "...makes me question myself, like it's a sign of failure, I'm failing her in some way. And I feel guilty...can't be meeting her needs if she needs splints on" (p7).

Impact on subject of restraint

People subjected to the use of restraint have reported being re-traumatised, as well as experiencing a sense of violation of their integrity (Strout, Ramcharan, Nankervis, Strong, & Robertson, as cited in Chan, LeBel, & Webber, 2012). Physical restraint can place people with disabilities in degrading and cruel positions (Wilkins, 2012). The use of restrictive clothing as restraint has been shown to reduce positive behaviours in people, such as play and social interaction behaviours. One study examining the views of ten participants with learning disabilities demonstrated diversity in how they reportedly felt about staff that were performing restraint. Six service users said they did not consider the staff enjoyed performing the restraint, other users did not consider there was an effect for the staff in performing restraint (Jones & Kroese, 2006). Service users also demonstrated feelings of subordination and subjection. They also demonstrated the belief these interventions were sometimes necessary for protection.

An analysis of nearly four thousand incidents of seclusion, restraint, and rapid tranquilisation was conducted by Sequira and Halstead (2001). In addition to the examination of incident reports, Sequira and Halstead conducted semi structured interviews examining personal experiences of these emergency interventions. The results of this help to understand the consequences of those practices in a population which is perhaps more able to discuss their experiences. This study, which looked at those practices in an independent psychiatric hospital for people with developmental disabilities between 1996 and 1999, shows that the consequences of such practices might be: physical pain; anxiety/mental distress; the perceived negative intentions/feelings of nursing staff involved; and anger or the urge to express aggression (Sequira & Halstead, 2001). It is interesting to note that the service users' perceptions were that staff may use these interventions to punish or control the person, as well as the perception that staff felt anger or hatred towards the person, or might enjoy using these techniques. This highlights the other consequences of restraint that may be somewhat less visible. The study concluded that people with disability often have difficulties speaking out, and indicates that the role of the professional is to facilitate this speaking out so that their experiences can be heard.

Cost of care

The use of restraint may also be expensive for organisations, in that it may prolong the recovery of some patients and thus raise the cost of care (Substance Abuse & Mental Health Services Administration, 2005). In reality, there are economic benefits associated with the elimination of restraint and seclusion (Chan, Lebel, & Webber, 2012). Obviously, this can be an important incentive for organisations if the alternatives to the use of restraint are cheaper for organisations.

In summary, the potential for negative outcomes associated with the excessive use of restrictive interventions is well documented (Sturme, 2009). Williams (2009) recommends that, given the fact that direct care staff implement restraint most frequently, every single incidence should be reviewed by a health professional.

The most effective method to reduce restraint related risks is to reduce the incidence of the use of such restraint (Allen, 2000). An examination of the service system issues likely to lead to an increased use in restraint is vital in determining how to address the use of restraint in a jurisdiction such as Tasmania. In addition, the prevalence of the use of restraint is also useful information, which may help to determine whether there is indeed a need to intervene and if so, to help establish a baseline so that the intervening strategies may be evaluated. There is little data on “environmental” restraint, as this definition is somewhat unique to this jurisdiction. Differences in definitions and reporting processes make it difficult to compare Tasmanian data with that from other jurisdictions.

Use of restrictive interventions in disability services

From 2010-2011, the Victorian Office of the Senior Practitioner found a two per cent decrease in the use of restrictive interventions (restraint, chemical, mechanical, physical, or seclusion) from the previous year (2009–2010), and a further two per cent decrease since the 2008/2009 financial year (Office of Senior Practitioner Annual Report, 2011). This data was collected through an online data collection system, the “Restrictive Intervention Data System” (RIDS) (Webber, McVilly, Stevenson, & Chan, 2010). RIDS is a data collection system that was been developed to report and keep record of incidents of routine or emergency restrictive interventions.

In the period 2007-2008, approximately nine percent of people receiving a disability service were subjected to a restrictive intervention (chemical, mechanical, or seclusion). This reporting is a requirement of the *Disability Act (2006)* (Vic). The electronic data collection system also allows for disability service providers to develop an online BSP. The use of such a data system enables services to monitor their own plans and their use of restrictive interventions, and also allows the Office of the Senior Practitioner (OSP) to collect data regarding patterns of use, and therefore areas that may require address. For example, in a study examining the use of restrictive intervention in respite

services in Victoria, Chan, Webber, and Hayward (2013) found approximately twenty eight percent of the total number of people with disability who are subject to restrictive interventions were from respite services. The majority of the restraint used was defined as chemical restraint.

Currently, Victoria is the only state with this robust data collection method. Webber, Mcvilly, Stephenson, and Chan (2010) suggest that if such a system was used widely, there would be more data with which to provide national benchmarking around restrictive interventions. The data would also provide more useful information if the definitions across jurisdictions were consistent.

When comparing, through internal data collection, the number of Tasmanian service users to the rate of restrictive intervention reporting in the 2012/13 year, it is evident less than one percent of the service users have reported restrictive interventions in place. Either the rate of use in Tasmania is much less than that in Victoria, or there is significant work to be undertaken in seeking compliance in reporting requirements from Community Service Organisations (CSOs).

Queensland legislation outlines the need for the monitoring and reviewing of restrictive practices (*Disability Services Act 2006* (Qld)). This Act aims to reduce or eliminate the need for use of restrictive practices in the disability service sector. The Act allows the use of restrictive practices under certain circumstances. Initial implementation of this Act created some issues: for example, there was ambiguity over who would be held accountable for the monitoring and reporting of restrictive practices (Paley-Wakefield, 2012).

Data has been collected to help explore the extent of physical restraint in Queensland (Wooderson & Meyer 2010). A survey based on Deveau and McGill's (2009) geographical survey of residential services in England was devised to target all government and non-government organisations that provide accommodation support to adults with disabilities. A twenty item survey sought information about characteristics of the organisation, use of physical restraint, policies on physical restraint, staff training in physical restraint techniques, and staff injuries. With a response rate at 23.6%, preliminary data collection in 2010 revealed that physical restraint is used by more than half of the respondent organisations in Queensland (Wooderson & Meyer, 2010). No psychometric properties of this questionnaire were evaluated and the results would be treated with caution due to small sample size. The study makes recommendations about further research, for example: a follow up survey to determine the influence of the implementation of the statutory requirements, examining the experiences of service users and examining the factors that may influence restraint within organisations in order to help develop effective strategies for reducing the use of restraint.

In the original study, Deveau and McGill (2009) surveyed adult residential services in one region of the UK. The results showed the use of physical intervention was reported by forty seven percent of the services. Of those services, sixty five percent reported having policy governing its use

and seventy nine percent provided staff training. Methodological issues include: a low response rate similar to the Wooderson and colleagues' study (twenty five percent); only surveying one region; and the generalising of the results. This study also only identified the prevalence of one type of restrictive intervention.

In response to a recommendation of the Honourable W.J. Carter QC a "Centre for Excellence" was established by the Queensland Government. This centre was to help meet the support needs of people with disability and severe behaviours of concern. One of the aims of this centre was to provide advice and guidance on techniques defined as restraint (McVilly, 2008). Its aim was to assist finding alternatives to and reducing numbers in need of restrictive interventions.

Disability Services Act 2012 (NT) defines restrictive intervention as including chemical and physical restraint, seclusion, and restriction of access. This legislation requires that each resident of a facility has a BSP to help address any behaviours of concern, and outlines the use of the proposed restrictive intervention. In the Northern Territory, the monitoring and reporting of the use of restrictive interventions is primarily conducted by the support organisation. The Chief Executive Officer of the organisation reviews the support plans, and records of the use of a restrictive intervention are made and kept by the service.

McGill, Murphy, and Kelly-Pike (2001) collected data about other types of restrictive interventions in the UK, through a similar methodology to the Deveau & McGill (2009) study. A questionnaire was posted to service providers from three samples, based on the following criteria: (a) those that had attended a physical intervention conference and/or purchased a policy document; (b) operated in a specific geographical area in England; and (c) operated specialist assessment and treatment settings for children/adults with intellectual disabilities in the UK. Their results indicate restraint is used monthly or more often in sixty eight percent of the sample, with seclusion and chemical restraint being used thirty seven percent and twenty three percent respectively. Protective devices were used less (twelve percent). Not previously investigated was the multiple uses of different types of physical interventions, and the authors found this was at a rate of fifty five percent. The response rate for this study was just less than forty percent. The study concludes that the data should be interpreted with caution due to the likelihood that the self-report data may be an underrepresentation of the use of restrictive interventions due to social desirability.

Use of Restrictive interventions in other contexts

Psychiatric services

A literature review examining restraint use with psychiatric inpatients in the UK, Australia, Canada, and New Zealand demonstrates that this information, similar to the disability sector, is

relatively scarce (Stewart, Bowers, Simpson, Ryan, & Tziggil, 2009). Differing methodologies were utilised for studies: for example, review of incident reports; questionnaires; repeated measure designs to measure the effectiveness of training programs; and qualitative studies examining staff/patient attitudes. Incident rates varied and were difficult to compare. Stewart and colleagues (2009) concluded that, given the prevalence of the use of restraint, there is a pressing need to improve the quality of basic information recorded, and a need to employ more rigorous research methods when examining this area.

A literature search reviewing studies of the prevalence and determinants of seclusion and restraint in children and adolescents in psychiatric settings revealed only seven publications which addressed the topic (De Hert, Dirix, Demunter, & Crooell, 2011). Recently, Dunn (2013) reported that in New Zealand (NZ) more than 1,000 mentally ill patients spent a total of 60,000 hours in seclusion in 2012. This is in spite of the ministry attempting to reduce the use of the practice. NZ Mental Health Foundation Chief Executive Officer (CEO), Judy Clements stated the pace of reduction was very slow, and "...we don't see it [restrictive intervention] having a place. We shouldn't be locking people in windowless rooms in the twenty first century" (para 15).

On the basis of figures from Australian Institute of Health and Welfare regarding the total numbers of patients admitted to inpatient facilities (AIHW, 2008), and the Australian Council of Health Care Standards (ACHS, 2007) outlining the proportion of patients subjected to the use of seclusion is at ten percent, the Australian National Mental Health Consumer Carer Forum (NMHCCF) concludes there are just under twelve thousand episodes of seclusion in Australia each year- that is seclusion occurring an average of thirty three times across Australia each day (NMHCCF, 2009).

It has been recommended that the UK adopt approaches similar to those in certain states of Australia (Paley-Wakefield, 2012). That is, due to the risk of restraint related injuries, death, and abuse, the legislation against the use of certain techniques be implemented.

A fifteen year follow up study examining the effects of legislation of the reduction of restrictive interventions (seclusion and restraint in particular) has been conducted in Finland (Keski-Valkama, Sailas, Eronen, Koivisto, Lonnqvist, & Kaltiala-Heino, 2007). Finland joined the European Convention of Human Rights in 1990, and implemented the fundamental rights in 1995. As a result, their Mental Health Act was amended three times to address the use coercive techniques in mental health settings, as well as the status and rights of patients. Keski-Valkama and colleagues (2009) examined the incidents of seclusion and restraint in patients by staff recording each incident. The authors concluded that whilst legislation, deinstitutionalisation policy, and discussion all emphasise the reduction of coercive measures, this is not reflected in practice. Keski-Valkama and colleagues

(2009) suggest that changes cannot be achieved solely through legislation, that education programs together with laws and explicit regulations are required.

The current NSW Mental Health Commission Chairman, Professor Allan Fels, reports that this organisation receives more complaints about seclusion and restraint than anything else (ABC, 2013). He states “It is a sign of a mental health system not working well, when so many people have seclusion and restraint” (para 16). The commission called for Australians to sign a petition calling for the elimination of seclusion and restraint of all patients in the health care system (ABC, 2013).

South Australian Health Minister, Jack Snelling commissioned a report into the South Australian Mental Health System. This report found patients are often “sedated and shackled” and describes this as a serious human rights issue. The South Australian Government is looking at making structural changes in response to this report (ABC, 2015).

Dunn (2013) found that whilst the NZ Government aims to stop the practice of seclusion, every health board offering mental health service is still using the practice.

Tasmanian Health Organisations are examining their position on the use of restraint, for example chemical sedation, particularly in emergency departments. This is reflected in amendments in the revised *Mental Health Act 2013* (Tas), which allows for significant improvement in the protection of the rights of mental health service users in Tasmania. Under the new *Mental Health Act 2013* (Tas), a person may only be restrained following approval from the chief civil psychiatrist or chief forensic psychiatrist.

However, in spite of national safety priorities in mental health aimed at the reduction of restraint and seclusion, Tasmania has had an increased seclusion rate since 2009-2010. There was some reduction in the use of physical and chemical restraint- however, not the same rate of reduction as seen in other states (ABC, 2013). According to Darren Carr from the Mental Health Council, the national recommendations have not been implemented in Tasmania by the state government (ABC, 2013). There is a movement to develop consistency about the use of such restraint amongst state-wide Mental Health Services, Ambulance Tasmania, and Tasmanian Health Organisations.

Children's services

The use of restraint in children's care and accommodation services in New South Wales was highlighted in 2001. Research and a subsequent report was commissioned by the Community Services Commission (Flynn, 2001). This research consisted of a survey of children being supported through the Supported Accommodation Assistance Program (SAAP), and out of home care. An examination of the behaviour intervention policies, the availability of practice guidance, and the type and availability of training for staff and carers was also included. Respondents were asked whether

the agency allowed for the use of restraint, what type of restraint was allowed under what circumstances, and whether training was provided in use of restraint. Results showed approximately one third of 88 service respondents services permitted the use of restraint, although many said it was used as a last resort. Of those services surveyed, twelve services allowed staff to use restraint without explicit training in the use of restraint. The study recommendations include the need for ensuring clear policy is provided in the use of behaviour intervention and restraint. This should be developed in consultation with major stakeholders, including representatives of children and young people, service providers, employees, and carers. The Community Services Commission encouraged out of home care and supported accommodation services to review their existing policy and practices, in consultation with those stakeholders.

Whilst within Australia there is agreement that restraint is potentially dangerous, legislation is such that the practices are likely to be lawful (Day, Daffern, & Simmons, 2010). There is no specific mention or regulation of restrictive interventions in the *Children, Young Persons and Their Families Act 1997* (Tas). Presumably this means that restraint and seclusion can be used with children who fall under the jurisdiction of this Act, without any regulation or monitoring of its use.

Education

The *Education Act 1994* (Tas) makes no mention of the use of restrictive interventions. The Act, and associated policy “discipline guidelines”, outline the sanctions of detention, suspension, exclusion, expulsion, and prohibition as methods of discipline (Department of Education, 2013). This act is under review; however, it is unclear whether the issue of restrictive interventions will be addressed.

Victoria’s Equal Opportunity and Human Rights Commission examined how well students with disabilities fare in government, Catholic, and Independent schools across Victoria. This study examined the experiences of more than 1800 students, parents, and educators. Thirty four parents in the study reported the use of restraint on their child at school. One hundred and twenty eight parents reported that their child had been placed in a ‘special room’. Five hundred and fourteen educators had used restraint and reported they felt inadequately trained to manage the situation. There is no oversight or monitoring of the use of seclusion and restraint in Victorian schools. The Commission made the recommendation that the regulation of restrictive intervention is transferred to the Office of the Senior Practitioner (Victorian Equal Opportunity & Human Rights Commission, 2012). There is no legal requirement for a teacher in a school in Victoria to report the use of restraint or seclusion (ABC, 2013).

A similar situation exists in Scotland, where there is currently a petition seeking the Scottish parliament to urge the Scottish Government to introduce guidance around the use of restraint and seclusion in schools (Scottish Parliament, 2015).

In the US, there are no federal laws restricting the use of restraint or seclusion in public or private schools. It has been recommended that the use of restraint and seclusion in schools should be addressed at a National level in the US. Without this, there is the risk that a lack of uniform standards for such practices might lead to unreasonable control by others (Miller, 2011).

Aged care

A review of literature examining the prevalence of restraint use in aged care, reports that it ranges between forty one and sixty four percent in nursing homes and between thirty three and sixty eight percent in hospitals (Hamers & Huizing, 2005). The main reason cited for use of restraint was safety, that is, the prevention of falls. The variation in statistics is explained by differing definitions of restraint used by researchers. The reviewers noted the use of restraints, regardless of the reason they were in place, had negative consequences and adverse effects. For example, the rate of death and serious injuries is increased. The authors also question whether or not the use of restraint is an adequate strategy for the prevention of falls. Falls and issues with balance and coordination were amongst the negative consequences that were found. The authors cite studies that indicate that reducing the restraints does not lead to an increase in the number of falls or fall related injuries, and similarly with the use of bed rails. For example, a study examining the safe reduction of bed rail use in long term care, showed reduced patient falls from bed with no increased injuries (Hoffman, Powell-Cope, MacClellan, & Bero 2003). This program included three components: an interdisciplinary team who identified safety concerns and barriers to the reduction of use of bedrails and included therapeutic aspects into the care of the elderly; alternatives to bed rail use; and the art of persuasion which included talking to the elderly person and their family about the advantages of alternatives to bed rails.

An attempt to clarify the prevalence of physical and chemical restraint in aged care was considered necessary due to such variation as described above (Meyer, Kopke, Haastert, & Muhlhauser, 2008). A cross-sectional study was conducted over a twelve month period in aged care nursing homes in Germany, and found that the use of physical restraint is routine, that twenty five percent of residents received at least one device such as bedrails, belts, or chairs, for example. The use of psycho-active medication was high. This prevalence data was collected through observation of restraint. This data was compared with justification for restraint use. Authorisation for the use of restraints is required in Germany. This study found that in forty two point nine percent of cases of mechanical restraint, a judge had authorised its use and in ten point nine percent, the resident themselves had given written consent. Thus, less than half of the use of restraint was unlawful. The

authors of this study comment that if the desirable is to be achieved; that is, a restraint free nursing home sector, a paradigm shift for nursing staff is required. Education regarding alternatives to the use of restraint, and reasons why restraint should not be used, may not be sufficient. The reasons behind the use of restraint were not examined in the study, and this was identified by the authors, as a methodological issue; for example, bedrail might be used to prevent falls from bed rather than to control behaviour. Nurses were not asked this information due to the likelihood that they would provide socially desirable answers. A strength of the study was the researchers directly visiting the centres regularly to check for data completeness and plausibility. Nurses' responses were also verified through direct observation within scheduled visits.

Use of restrictive interventions in families

There is not a substantial amount of research examining the area of adults with disabilities and the use of restraint by family members. Allen, Hawkins, and Cooper (2006) aimed to examine parents' experience of managing challenging behaviour and physical interventions. Under the Tasmanian legislation, such physical interventions would be deemed as personal restrictive interventions. By surveying seventy two respondents, the study showed that the vast majority of parents had used physical interventions, and only twenty five percent had been trained in the use of such procedures. Injury or fatality was reported in seventeen percent of respondents. The authors suggest that adequate training is not provided to parents, due to the legislation being aimed at training for staff and not natural carers. This is certainly the case in the Tasmania, where the primary focus in the legislation is on training and development for disability funded service providers.

Parents face issues such as complexities of decisions around restraint; the lack of clarity around the least restrictive option; the need for increased levels of support around managing challenging behaviour and determining the function of behaviour; as well as a lack of adequate resources (Elford, Biel, & Clark, 2009). A study conducted by these authors involved interviewing a small number of British parents (n=7), all of whom care for a son or daughter with a disability. A semi structured interview was used to explore the experience of restraint, with the aim of revealing implications for professional services in the area. The study revealed the key to addressing these issues is the relationship between professionals and services. The elements of a successful relationship were considered to be listening, clear communication, and provision of support. This was not reported by all parents in the study. Parents reported they could feel judged, confused by the bureaucratic process, isolated, ignored, and kept in the dark. Authors of the study recommend an open culture be promoted between parents and services regarding the use of restraint. These findings are not dissimilar to other findings. Mothers of children with disabilities had problematic dealings with professionals, feeling as though their character and worth as a mother were being continually scrutinised (Todd & Jones, 2003). This is an important issue in relation to the use of restrictive

interventions, particularly if the person with the disabilities accesses a mix of home and specialist services.

Jurisdictions comparison of use of restrictive interventions

It is difficult to compare the rates of restrictive practices across regions and client groups given the differing definitions and differing methodologies for data collection. A lack of clarity in definitions is identified as one of the major barriers to reducing the incidence of restraint (Australian Department of Health and Ageing, 2005). This contributes to difficulty measuring and comparing the incidence across jurisdictions and within services. States within Australia, aside from Victoria, Queensland, Northern Territory, and Tasmania, provide regulation only at procedure or policy level provided by state government.

Overall, despite being difficult to compare, it appears that the rate of use of restrictive interventions is higher than what would be considered in the literature as necessary. Evidence demonstrates concentrated efforts such as those in Victoria, can lead to the reduction of use. This indicates that data collection, education, and targeted programs can reduce the incidence of restrictive interventions. In Tasmania, in particular, this was one of the reasons for the inclusion of regulation and monitoring of restrictive interventions in the new Act. The role of Senior Practitioner is designed to help reduce this rate by monitoring, reviewing, and assisting in the development of the sector. In order to determine the efficacy of this role, and provide a basis for implementing services, a baseline of the use of restrictive interventions is required.

Factors influencing the use of restraint

Service providers claim that it is sometimes necessary to use restraint, for a variety of reasons, including the need to prevent people from harming themselves or others (McGill, Murphy, & Kelly-Pike, 2009). The most common of these being for reasons of safety due to lack of resources, including staff resources, lack of awareness of alternatives, and a lack of ability to implement alternatives with the current resources.

Factors which influence the use of restraint and seclusion have been identified as being: policy; physical environment; staffing and client issues (McVilly, 2008). It is apparent that the use of restrictive interventions is more likely under certain conditions and with certain population characteristics (Spivakovsky, 2012). These include the culture of the service provider and factors relating to the person's disability, for example. These will be elaborated upon below.

Individual characteristics

Gender

A database review conducted by Webber, McVilly, and Chan (2011) found that in Victoria, more males than females with disability were subjected to restrictive interventions. This paper concluded the reasons for this may be that males may exhibit more behaviours that elicit restrictive responses, such as destructive or aggressive behaviours, or that it is more socially acceptable to use restrictive interventions with males rather than females. The data which was examined did not allow for a clear conclusion to be made. Women are more likely to be chemically restrained following a violent incident (Sequeira & Halstead, 2001). In contrast, men were more likely to be subject to seclusion. A review of literature examining the use of manual restraint in mental health services found that manually restrained patients tend to be younger, male, and detained under mental health legislation. However, the review recommends interpreting these findings with caution due to differences in research questions examined in the studies reviewed. The review concludes by stating that, where there are a range of factors considered together (for example nursing roles, aggression of patient and so on) gender is much less important (Stewart, Bowers, Simpson, Ryan, & Tziggili, 2009).

Age

Stewart and colleagues conducted a review of forty five empirical studies of manual restraint, mainly from the UK, and found that three reported the average age of restrained patients, which were 31, 33 and 37 years (Stewart, Bowers, Simpson, Ryan, & Tziggili, 2009).

Webber, McVilly, and Chan (2011) examined Victorian data and found that more adults than other age groups were subjected to restrictive interventions; however data regarding children was not extensively reported. In the elderly population, a summary of current literature reporting on this topic shows that the main predictors for use of physical restraints are poor mobility, impaired cognitive status, high dependence, and a nurse's opinion that the patient is at risk of falling (Hamers & Huizing, 2005). In terms of nursing home care, reduction in physical restraint use is influenced by the characteristics of the residents as well as environmental factors (Kayser-Jones, 1992).

Disability

The review of Victorian data revealed that all people subjected to a restrictive intervention in Victoria either had an intellectual disability and / or an Acquired Brain Injury, and the majority had more than one disability. Similarly, restraint in nursing homes appears to occur more often when the patient is cognitively impaired (Sullivan-Marx, Strumpf, Evans, Baumgarten, & Maslin 1999).

Challenging behaviours are prevalent in persons living with intellectual disability, in particular aggression and self-injury (Matson et al., 2005). Behavioural and psychological symptoms of dementia also leads to an increased use of physical restraints (Sullivan-Marx, Strumpf, Evans, Baumgarten, & Maslin 1999).

Behaviour Risk

Webber and colleagues (2011) found the main reason reported for the use of seclusion was “harm to others” (p 504). “Harm to self” (p 504) was the main reason for use of chemical and mechanical restraint. In a review of fifty two cases of restraint use, Sturmey, Lott, Laud and Matson (2005) found that psychopathology and challenging behaviours were most likely to be associated with the use of restraint. Physical restraint has been shown to be used in seventy four percent of the incidents of physical aggression (McGill, Murphy, & Kelly-Pike, 2009). This data was collected through a postal questionnaire of service providers. The most common challenging behaviours reported were physical aggression and intense displays of emotion.

Organisational factors

Future data may be enhanced by the inclusion of information about the service context in which interventions were used (Webber, McVilly, Fester, & Chan, 2011). For example, the inclusion of data regarding behaviour support practices, environmental service, and staffing issues could enhance studies. It was found that environment is important, including staff behaviour and therefore the use of such interventions. For example, physical restraint is often incorporated into therapeutic behaviour support plans for people with disabilities (Luiselli, 2009). The quality of these support plans, which includes assisting staff to understand the function of a behaviour of concern, can affect the rate of use of restrictive interventions (Webber, McVilly, Fester, & Chan, 2011). An examination of the antecedents to incidents of restrictive intervention, through an analysis of records associated with each incident, reveals the most common were transitions between other activities and table top activities (Finn & Sturmey, 2008). The identification of antecedents is an integral part of a behavioural assessment and forms part of a behavioural support plan.

Services may remain susceptible to misusing coercive interventions for several reasons, including power inequalities between staff, levels of staff, service users and between professional disciplines (Paterson et al., 2011). Paterson found that services are characterised by low status staff who may seek to restore their self-esteem by abusing the power they have at work, by retaining almost complete control over the lives of service users.

Attempts to reduce the use of restraint were met with some challenges at an Australian forensic mental health hospital (Maguire, Young, & Martin, 2011). Attempts were made in this

setting to employ the techniques shown to be successful in restraint reduction in North America. These were: leadership guiding organisational change, workforce development, consumer involvement, use of seclusion reduction assessment and planning tools, use of data to support practice, and debriefing techniques. The study concludes that in this setting, at times, the use of restraint may still be necessary as nurses must provide a safe environment whilst managing volatile patients, and at times may have little option but to seclude such patients. Factors such as patient characteristics, opportunities, staff confidence, sound risk assessment, and higher staff-patient ratios influence the reduction of restraint and seclusion. Interestingly, this study showed a decline in the amount of restraint and seclusion, and staff saw this management technique not as punishment, but as therapeutic and necessary for the safety of the unit.

A program utilising four components almost eliminated the use of restraint, reduced worker injury, and injury related costs. Organisation components such as participation from every employee, promotion of a philosophy of comfort and support, provision of alternative treatment strategies and training, and the review of progress are important factors in restraint use minimisation (Sanders, 2009). These factors are often included in a BSP. Alternatives to the use of restrictive interventions rely on understand the needs of people living with disability. This is achieved through a behavioural assessment and resulting support plan.

A synthesis of literature found that organisational factors of leadership, management, and monitoring of physical interventions have effects for minimising the use of restraint, (Deveau & McDonnell, 2009). That is, the leaders of the organisation should receive information about the use of restrictive interventions and use these as indicators of quality. In addition, this data should be used to inform staff training and practice and alternative strategies should be taught.

Mindfulness has also been shown to decrease the use of restraint. In a study that sought to determine how training an organisation's staff in mindfulness affected the use of restraints in people with intellectual disabilities and aggressive behaviours, Singh, Lancioni, Winton, Singh, Adkins, and Singh (2009) found that as mindfulness training progressed, the use of restraints decreased to the point that almost no use of restraint was being used by the end of the twelve week study. This is in spite of those staff being behaviourally trained. The authors hypothesise that, in attempting to pre-empt and control aggressive behaviour, staff may elicit aggressive behaviours. Mindfulness changes these perceptions, so that pre-emption and control of these behaviours decreases, and the number of incidents decreases as a result. More recently, Brooker, Webber, Julian, Shawyer, Graham, Chan, and Meadows (2014) found that mindfulness training assisted residential support staff to respond to behaviours in a less restrictive manner.

Similarly, Singh, Lancioni, Winton, Curtis, Wahler, Sabaawi, Singh, and McAleavey (2006) provided group home staff with behaviour training and later with mindfulness training, and then

assessed the impact on aggressive behaviours and the numbers of learning objectives mastered. There was some reduction in interventions for aggression following behavioural training; however this only decreased substantially following mindfulness training. Whilst there was some increase in learning objectives mastered following behaviour training, greater and more consistent increases were found after mindfulness training. Further evidence is also provided by Singh, Lancioni, Karazsia, Myers, Winton, Latham, and Nugent (2015) for the reduction/elimination of the use of restrictive interventions when staff have participated in mindfulness-based training.

Six core strategies are recommended by the Disability Policy and Research Working Group (DPRWG) to help reduce the use of restrictive interventions in disability services. DPRWG is a standing committee of the Community and Disability Services Ministers Advisory Council. The first of those strategies is a person centred approach which includes the development of BSP, assessment tools for the determination of behavioural and environmental risk, and evidence based interventions (Huckshorn, 2006).

There is an expectation that government will provide strategic direction to service providers, and service providers will form appropriate governance structures to provide support mechanisms to help reduce the use of restrictive interventions. An organisational behaviour management approach to increase behaviour intervention plans and decrease the use of restraint was used over the course of seventeen months (Williams & Grossett, 2011). Results show behaviour intervention plans were more than doubled, and restraint decreased by close to eighty percent. This was achieved through the use of the following organisational contingencies: (a) A behaviour intervention plan was developed if mechanical restraint was used to stop self-injurious behaviour, enhance wound healing, and/or control physical aggression. The goal of the plan was to reduce the reliance on the use of restraint; (b) A behaviour program was developed and implemented if a person caused injuries to self or others through problem behaviours. Positive feedback was provided to those who complied with the above contingencies.

A further recommendation is made, based on studies such as Webber, Richardson, Lambrick and Fester's (2012) findings, that data can help inform what is effective in the reduction of restrictive interventions (for example, the quality of support plans). This recommendation states that data should be collected at the organisational level, and standards for achievement to be set from this. In addition, it is recommended that an auditing tool of restrictive practices is utilised.

DPRWG (2011) suggest there is evidence that support staff who understand positive behaviour support, functional behaviour assessment, trauma informed care, risk assessment, and alternatives to restrictive interventions are then able to reduce the use of restrictive interventions. Workforce development around those issues is therefore recommended. An integral aspect of this is debriefing staff following the use of an unplanned restrictive intervention, and encouraging the use of

tools that reduce the use of restrictive interventions as per above training. These recommendations have been proposed for adoption in Australia by the DPRWG (DPRWG, 2011).

Duty of care/dignity of risk

Organisations are required to balance occupational health & safety requirements with other legal duties. Duty of care is the obligation to take reasonable care to avoid injury to a person whom it can be reasonably foreseen might be injured by an act, or omission. It is the principle of reasonable care to avoid injury to a person whom it can be reasonably foreseen might be injured by an act, or omission. It is the basis for civil action (ADHC, n.d.). Providers are required to ensure the safety of both support staff and the people they are supporting. Historically, organisations supporting those living with disability tended to focus on avoidance of risk for those whom they support, by limiting their spheres of behaviour, interactions, jobs, recreation, relationships, and so on (Perske, 1972). Increasingly, there is an understanding that people living with disability have a right to assume risk commensurate with their level of functioning. Dignity of risk is the belief that each person with a disability is entitled to experience and learn from life situations, even if these, on occasion, may be a threat to their well-being. Each person with a disability experiencing a risk, of which they have been informed, should receive support in the situation.

The Victorian OSP commissioned the development of a resource to support the reduction of the use of restrictive interventions. This documentation “Roadmap Resource for Achieving Dignity” has been written for CEOs and senior managers in organisations, and outlines methods to achieve new ways of thinking about their actions; organisations rethinking how they organise support staff and policy makers adopting new policies for the sector, with an increased human rights focus. A significant aspect of this documentation is the teaching of new ways to manage risk. This helps organisations' boards and CEO/management consider how to balance the risks of allowing people with disability to choose to take a risk, and the organisation's duty of care. The road map recommends that policies should identify hazards, mitigate the hazard to identify calculated risk, balance the risk against the benefit to the person, and ensure that choice and fairness are integral to calculating what risk is acceptable (DHS, 2012).

As leaders in the field of provision of data, and who have experienced successful reduction in the use of restraint in the state of Victoria, the OSP have published many papers, including directions papers, demonstrating the efficacy of alternative techniques. For example, McVilly (2008) outlined evidence based positive alternatives to the use of physical restraint. This included the following: multi-element interventions- including person centred planning, active support and positive behaviour support; counterintuitive strategies- including the provision of high density, non-contingent

reinforcement programs; room based interventions-for example, sensory rooms; sensory interventions; low arousal techniques; intensive interaction for people with severe, profound, and multiple disabilities; and mindfulness techniques for people with disabilities and those providing support services.

Similarly, the practice guide “Reducing Restrictive Clothing as Restraint” has been produced by the Office of the Senior Practitioner. This guide acknowledges that restrictive clothing may at times be used when people with a disability display behaviours that are difficult for parents, carers, and staff, as these behaviours may pose a risk which the parent/carer/staff person is trying to minimise. This guide recommends the use of a functional behaviour analysis to determine why the behaviour is being exhibited, and to help inform the intervention; rather than using the restraint to simply stop the behaviour (Haywood, 2010).

The use of such alternatives to restraint may represent a saving for organisations. LeBel (2011) found that residential providers who have reduced the use of restrictive interventions due to changes in organisational culture reported savings that exceed the cost of their use.

The following have been identified, by Rimland, as barriers to restraint minimisation in human services: leadership and change; attitudes and beliefs; resistance to change; clarity of definitions; clinical standards and practices; education and training; communication; environment; staffing dilemmas; and monitoring, review, and oversight and micro-level implementation practicalities. Rimland (2011) conducted this literature search to report on data relating to the strategies and barriers of minimising the use of restrictive practices in human services.

Relevance of the current study to Tasmania

In 2003, Tasmania had the highest rate of disability in Australia (Tasmanian Government, 2007), and three percent of the Tasmanian population had an intellectual disability (AIHW, 2008).

The primary target group for specialist disability services is the twenty two thousand Tasmanians under the age of sixty five that have a severe or profound disability. The Australian Institute of Health and Welfare (2008) determined that, in Tasmania, on any given day, approximately three thousand nine hundred and two Tasmanians receive disability services.

In 2007, the Tasmanian DHHS engaged KPMG, a professional auditing firm, to undertake a review of disability services. The intention of the review was to examine government funded disability services and make recommendations about the strategic direction and service models in line with worldwide best practice. The aim of the government was to deliver more effective outcomes for people with disabilities (KPMG, 2008). Seven recommendations were made, including building the capacity of non-government organisations (NGOs). This recommendation resulted in the outsourcing

of much direct service provision to the NGOs, as well as a single entry point to services coined “Gateway”. The next major reform Tasmania faces is the implementation of NDIS.

People with disabilities face stark health inequalities (National Health and Hospitals Reform Commission, 2008). When compared with the general population, people with intellectual disabilities have a lowered life expectancy, higher morbidity, higher rates of health needs, and more difficulty finding and getting health care (Balogh, Ouellette-Kuntz, Lunskey, & Colantonio, 2009). The Federal government’s reform agenda provides no direct answer to the health disadvantage experienced by people with an intellectual disability (Simpson & Lennox, 2011). Due to these health inequalities and requirements, particular support needs should be considered in future policy and service systems. Careful consideration of policy is essential. This is particularly relevant in Tasmania given the high rate of disability and associated inequalities.

The management of challenging behaviour is one of these support needs because of the prevalence of challenging behaviour amongst people with disabilities (Xeniditis, Russell, & Murphy, 2001). The management of challenging behaviour requires a particular set of skills in order to be effective. With recent reforms in Tasmania, the management of these behaviours of concern falls to community service organisations, rather than departmental employees. The department provides clinical teams to support community service organisations to do this.

In light of these recent reforms, it is timely that the situation in Tasmania is examined. Tasmania’s largest institution, for those with disabilities, Willow Court, has now been closed for fourteen years. There is now a greater human rights focus reflected in legislation. Provisions have been made in recent legislation to uphold the rights of those with disability by ensuring restrictive interventions are monitored and regulated, and ultimately not used with those living with disability. There is a need to determine how these changes will be received by the sector, and what barriers are seen to exist in the implementation of these changes. With most people living within the community, it is necessary to determine if practices have changed since deinstitutionalisation. If not, action is required in order to facilitate these changes, consistent with a more contemporary model of disability in society.

Understanding the incidence and nature of restrictive practices of local community service organisations is essential in understanding the most effective methods to minimise or obviate the use of restrictive interventions locally. New legislative requirements in this jurisdiction provide a unique opportunity to examine the implementation of Tasmanian specific legislation. Prior to the implementation of the Act, approval for the use of restrictive interventions was provided through an ethics committee. This data is unavailable due to jurisdictional/privacy issues, therefore specific Tasmanian data is not available. However, the views of those in the sector have been sought in order to gather evidence about the use of restrictive interventions in the Tasmanian sector.

Building on issues identified in other research, all major stakeholders will be consulted regarding the use of restrictive interventions in Tasmania, the recent changes to the Act, and the implications this has for the delivery of services. Data regarding the reasons behind the use of restrictive interventions or barriers to using alternatives will be examined. Information from families, staff, advocates, clinicians, and managers will be included in this study. Research to date recommends all stakeholders need to have a consistent philosophy if restrictive interventions are to be reduced.

Tasmanian disability services have experienced relatively rapid changes in recent years. This study is designed to examine any barriers to the implementation of these changes which address the regulation of restrictive interventions, with the view to ensuring best practice for the management of behaviours of concern. The management of behaviours of concern should not include the use of restrictive interventions. It is the intention of this study to determine how to implement the recent changes to reduce the use of restrictive interventions.

Chapter 2 in brief.

This chapter provides a summary of the literature relating to the use of restrictive interventions in the disability and other sectors. Chapter 3 will describe the study design in detail, and the aspects of the study which unfolded as the study progressed.

Chapter 3.

Methodology

Chapter 3

Method

This chapter details the methodological approach taken to investigating the current practices within the Tasmanian disability sector, and the views about the barriers to the effective implementation of alternatives to restraint from various stakeholder perspectives. This chapter includes details of the procedures for recruitment of participants, participant numbers, data collection, and analysis. The chapter outlines methodological considerations and ethical considerations.

The methodology utilised in this study evolved throughout the course of the study, due to developing opportunities that arose through my role as the Senior Practitioner, and this is therefore insider research. Mixed methods were used to obtain experiential and descriptive information and to help inform the direction of the study and work based practices. A quantitative component was used to determine some current practices within the sector. Mixed method research is a well-established methodology, particularly when an understanding of compiled information is required to inform social policies, as was the case in this study (Bryman, Becker, & Sempik, 2008). Such a method was used as it was not possible to get a complete picture from one method. I tried to ascertain the extent to which aspects of the Act had been implemented. When it was clear there were issues with implementation we utilised a qualitative approach to determine why that was the case.

To reiterate, I designed this study to examine Tasmania's implementation the parts of the Act that related to the regulation of restrictive interventions, and to identify any barriers to this implementation, with the ultimate aim of providing recommendations to assist the implementation. The study addresses the central question: what are the current barriers to the implementation of the relevant section of the Act that enables the regulation of restrictive interventions?

This study was exploratory, as there is a lack of research in the area of implementation of disability legislation in Tasmania as well as a lack of research about the regulation of restrictive intervention in the Tasmanian sector. One of my research aims was to lay the foundation for future research, and future directions for the sector.

The objective of exploratory research is to identify key issues, rather than to offer conclusive solutions to a known issue. The key issues I wanted to identify in this study are those associated with the implementation of the legislation aimed at the reduction of the use of restrictive intervention, if any. I wanted to identify any issues that may be applied to my practice in order to implement changes which will ultimately assist in the reduction in the use of restraint in Tasmania.

I identified issues throughout the course of the study, which helped to inform further data collection directions. Exploratory research has been described as an approach concerned with

discovery and generation of ideas or theory (Davies, 2006). These types of methodologies are common amongst Professional Doctorates (Fulton, Kuit, Sanders, & Smith, 2011). The nature of exploratory research is such that the researcher needs to be prepared to change the direction of the research depending on the findings (Saunders, 2007).

A Professional Doctorate is focused on work based learning and the development of an area of practice through the course of these developments (Fulton, et al 2011). My role as insider researcher/practitioner assisted in guiding the direction the study would take. As an insider I was able to determine the implications of the results of initial aspects of the study, and identify areas and participants for further investigation. Through the research, I was part of the system and influenced the system during the research process. It is therefore not possible to separate the professional role from the research role. There is a very strong relationship between my aims in my professional role and the aims of the research. As highlighted by Lester (2004), throughout a Professional Doctorate, the student works from within their role to develop new ideas which can then be applied to their practice, a combination of scholarly enquiry and professional practice. The two roles are inextricably related.

Due to the nature of this relationship and the Professional Doctorate, more blunt work based measures were used which did not necessarily have academic validity. These measures were developed in a work-based context by myself and in some cases by senior departmental personnel throughout the course of my professional practice. It is feasible to consider this a limitation of this study but also highlights a limitation of nature of this work.

Table 1 provides a summary of the data collection methods, the sequence, and main focus of each method (see over). Figure 1 shows the systematic approach to data collection.

Table 1 Summary of collection of Data.

	Data	Issues Explored
(a)	Survey (online) sent to CEO of disability funded organisations	Policy Use of restrictive interventions Compliance with legislation Staff understanding Staff training
(b)	Focus groups- Organisational Support workers	Barriers & how these can be overcome
(c)	Support worker checklist	Prevalence of practices
(d)	Focus groups- Departmental Clinical workers	Barriers & how these can be overcome
(e)	Interviews- advocate, family	Barriers & how there can be overcome
(f)	Written compliance letter (CEO/Managers)	Policy Training Compliance Understanding
(g)	Written survey-Departmental Clinical workers	Understanding and training needs

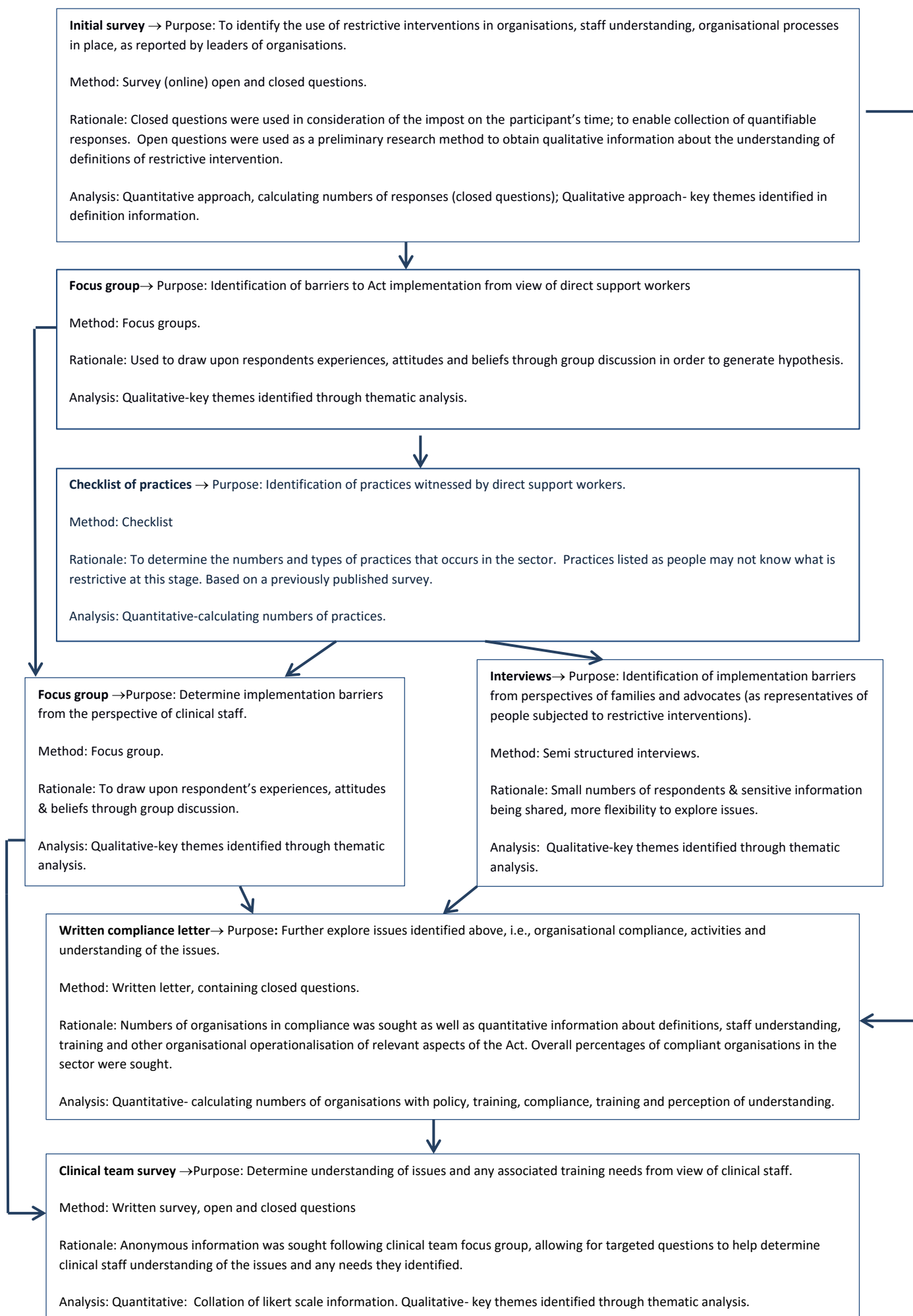


Figure 1. Methodology flow chart

Ethics approval

I forwarded an application for ethics approval to HREC (Ethics Reference: H0012443) (see Appendix E) and ethics approval was obtained. Two amendments were approved to include opportunities for further data collection that arose throughout the study: 6th August, 2013 and 24 June, 2014 (see Appendix F). This includes an ethics exemption to include data collected from the written compliance letter sent to the CEO's of organisations (group f above). Ethics approval was not sought specifically to include the information gathered in the organisational support worker focus groups (group b above). These focus groups occurred within the context of my professional practice.

Ethics approval was gained for all other groups: (a) (c) (d) (e) (exemption for (f)) and (g).

Methods

I utilised mixed methods in this research. The method was largely qualitative with the inclusion of the survey outlined below. The methods were as follows:

(a) Online survey

Drawing on other research undertaken in this field, I attempted to find research that examined the practices occurring within organisations. As the intent of this initial data collection was to determine the presence of activities that demonstrate compliance with the legislation, or steps towards implementation of the legislation, it was assumed that by targeting the leaders of the organisations, they could provide an overview of what occurs within that organisation. Deveau and McGill (2009) used a survey to examine practices in UK residential services. This survey was also used by Wooderson and Meyer (2010) to help determine the policies around physical restraint in Queensland. I modified the survey for the current study, and used an online forum to help determine the views of leaders (CEOs or Managers) of organisations. I used this survey to examine their views about what happens within their organisations, in terms of restrictive practices, and policies and procedures to enable the use of alternatives to the use of restrictive interventions (see Appendix A). The information requested was based on the information required from organisations in the regulation of restrictive interventions, as per the Act. The survey, which I altered for the purpose of this current study, included a mixture of closed and open-ended questions.

(b) Focus groups

I used a focus group method to gather the views of Tasmanian disability support workers, based in non-government organisations. Such a method can be used to develop an understanding of issues known to the examiner, and to develop understanding from the user's perspective (Bender & Eubank, 1994). When the focus group question is of interest to both the investigator and respondent, more

concrete and highly detailed answers result (Merton, Fiske, & Kendall, 1956). I selected this method due to the existence of evidence in the literature suggesting support workers may have low rates of literacy and low status within their organisations. The focus group method helps to provide a collective power for people. Through my facilitation of this collective power, we hoped that people would feel more able to articulate their views about the new Act and any barriers they saw to the implementation of this Act. In addition, good information was required in light of the previous poor response from leaders and managers of organisations.

I held additional focus groups separately, and involved the clinicians employed in DHHS, who typically provide advice to organisations about the management of behaviour. The questions I asked in these focus groups were identical to those asked of organisational staff, described earlier. These were questions about any perceived barriers to the implementation of the Act, the benefits of the Act, disadvantages of the Act, and any methods to remediate potential barriers to the implementation of the Act. I chose these questions to facilitate open discussion about the regulation of restrictive interventions. I did not contain reference to the specific section of the Act (part 6) relating to restrictive intervention. This was because we thought there might be other sections of the Act that affect the regulation of restrictive interventions and did not want to confine discussions. However the preamble discussion provided the reference and specific section of the Act to which I was referring as well as clarity around the topic being the regulation of restrictive interventions. Again, I applied this focus group method to this group in order to develop an understanding of the issues from their perspective. I understood due to my professional role, when discussing the Act, most people equate this to the sections relating to the use of restrictive interventions.

(c) Checklist

I consulted the same support workers from a variety of non-government organisations in Tasmania about the occasions of restrictive practices within their organisation, through the use of a checklist of practices (see Appendix C). My intention in including support workers was to gain valuable information about what happens at the ‘ground’ level of organisations in relation to practices and potential restrictive interventions. As those who work face to face with people with disabilities, the extent to which support workers considered they were able to implement the requirements of the Act was vital information. I used a checklist methodology, both in order to gather the information in the least intrusive and most timely manner, as well as to mitigate the impact of potential literacy issues. I derived this checklist from the practices listed in the Deveau and McGill (2009) survey and ensured each practice would be considered a restrictive intervention according to the Tasmanian legislation.

(d) Interviews

I employed an interview methodology to gather information from families and advocates of those supported. I verbally administered questions that allowed for discussion and clarification of issues as they arose. This group of people are impacted by the changes in the legislation and may experience support practices, including restrictive interventions, first hand. Therefore I considered it important to include their views. People living with disability may have difficulties understanding the issues or communicating the impact of these. Therefore, I chose advocates and families to help represent their views or to support them in participating in the research. Advocacy services are funded by the State Government's Disability Services to provide support to people living with disability in Tasmania.

My original intention was to employ focus group methodology; however, low numbers resulted in us interviewing participants instead. This was advantageous, as the issues raised were very personal and emotive. The semi-structured nature of these interviews allowed us to further explore issues as they arose. This approach is often used in healthcare, as the flexibility allows for elaboration, but also provides helpful guidance (Gill, Stewart, Treasure, & Chadwick, 2008). This level of honesty may not have been elicited in a group setting. I asked the same questions of interview participants and focus group participants.

(e) Written correspondence

On behalf of DHHS, I drafted a letter with the intention of gather information from organisations about their compliance with the specific sections of the Act, which relate to the regulation of restrictive interventions (see Appendix D).

(f) Written Survey

I drafted a survey to help determine clinicians' understanding of the requirements of the relevant sections of the Act (see Appendix H). Given the poor response rate to the previous survey, this survey was paper based, rather than online, and contained only five questions. I chose these questions on the basis of the most commonly received questions posed by the clinicians to me in my professional role. That is, they would ask for training in this area; and seek clarification about which practices fall under which definition of restrictive intervention and understanding their role in the process of regulation. Such semi-structured interviews can allow for enhancement of survey findings (Bryman, 2006).

Participant Recruitment

(a) Online survey

To implement the survey, I obtained a list of all DHHS funded non-government by using information provided on the Department of Disability and Community Services website as at December 2012 (N=76). I sent an email to the CEO (or similar) of each organisation outlining the intention of the study, including information sheet and consent form. The email also contained the link to the survey.

(b) Focus groups

Focus group participants were recruited from an information sessions which the department was holding across the state. The information sessions were designed to increase attendees' knowledge of the *Disability Services Act 2011* (Tas.) and more specifically the sections regarding the regulation of restrictive interventions. Attendees, who were organisational support workers, were asked if they wanted to participate in focus group sessions upon the conclusion of the information session. All attendees chose to participate in the focus groups, although they also had the choice as to whether they participated in the discussion once it had begun.

I held thirteen support worker focus groups state wide. The focus groups were held in the departmental regions of South, North West, and North. Two sessions were held in each region, one at night and one during the day, in order to maximise participation from shift-workers. These workers were employed by state funded community service organisations. Each focus group had approximately eight to ten participants in each (N=110).

In addition to these focus groups, we also invited all members of Tasmania's Disability Services clinical teams to participate in the focus groups (approximately thirty eight members). There is one team in each of the four Tasmanian regions: North, South East, South West, and North West. In total, seventeen members participated. The participant numbers in each region were as follows: North = 6, South = 6 North West = 5 (N= 17).

(c) Checklist of practices

The same 110 participants in the above-described focus groups were asked to complete the checklist of practices. 95 people completed the checklist.

(d) Interviews

I identified advocacy agencies from the DHHS public website, and forwarded an email invitation to these agencies inviting them to attend a meeting at a specified time and date, one in the North, one in the North West and one in the South of Tasmania. I also extended this invitation, via advocates, to

those being supported or their families, and specified that the advocates were welcome to bring anyone from these groups to attend as well. One advocate identified a family member of a person being supported who was willing to participate. Given that the focus group methodology could not proceed due to lack of numbers, this participant was interviewed by the researcher and academic supervisor. One advocate contacted me and expressed an interest in participation.

(e) Written Correspondence

I generated a list of disability-funded organisations from the public DHHS intranet. This included contact details for the organisation (seventy six in total). A total of thirty-four organisations responded (n=34).

(f) Written Survey

A written survey was provided to each member of the state government's Disability Service clinical teams. At the time, those numbers were as follows: North =10, North West =10, South East=8, South West = 10. A total of 11 responses were received.

Table 2 Snapshot of participant numbers

Participant group	Numbers
CEO/manager survey	17
Focus groups	19 groups- 127 subjects
Checklists	95
Interviews	2
CEO/manager compliance letters	34
Clinician survey	11

Data gathering

(a) Online survey

In the survey I asked a series of questions including whether the organisation has restraint related policy, and whether the organisation provides training in the use of personal or environmental restraint techniques.

Four responses were received indicating that the survey was not relevant for their organisation, for example, they received funding but did not provide direct support. Three undeliverable messages were received.

After one month, I re-sent the survey link and accompanying email to the remaining organisations (less those who indicated it was irrelevant and those which were undeliverable). After a further month, I pared the list down, by discussing the list of organisations with a project officer in the Department of Disability and Community Services, who helped identify which organisations provided direct support and therefore were relevant subjects for this study. I re-sent the email and survey link to these 44 organisations. Requests for completion of the survey were forwarded three times during the period December 2012 to February 2013. In total, seventeen out of the forty-four organisations completed the survey. Responses were received from:

- CEO=6
- Manager/Principal =6
- Manager of specific program=2

The remaining 3 responses were received from positions described as Secretary, Executive Assistant and Support Services Coordinator.

Due to this low response rate, I consulted a senior manager from the peak body for non-government disability service organisations, National Disability Services (NDS), about the possible reasons for it. This Manager reported that it was his opinion that leaders of organisations would be hesitant to respond to the survey due to the potential to reveal their level of non-compliance with the legislation, or lack of understanding of the issues. He stated other possible reasons might be time constraints, or lack of understanding of the importance of the issues, therefore rating this survey as a low priority to respond. In addition, a clinician based within a community sector was also consulted about her perception of the reasons for the poor response rate. Similar to the above, she was of the view that people were concerned about exposing their lack of knowledge and their organisations unlawful practices. She was also of the view that CEOs of organisations at that point did not quite understand the importance of this issue.

I was interested in determining other stakeholder's perceptions of organisational performance in this area, particularly given the low response rate to the initial survey. In order to get a depth of information to guide the direction of the study, I employed a focus group methodology with alternative participant groups.

(b) Focus groups & (c) Checklist

Participants in the focus groups were attendees at a training session-invited and supported to attend by their organisations (that is, paid for their time) to help understand the new regulation of restrictive interventions under the Act and the implications for those who provide direct support.

We asked focus groups across the state the same questions (see Appendix B). These questions were directly related to the aims of the study, and essentially relate to perceived barriers to the implementation of the regulation of restrictive interventions aspects of Act, and ideas of overcoming these barriers, as well as advantages and disadvantages of particular aspects of the Act.

To decide on group membership, I gave participants a number between 1 and 4 and allocated them to group 1, 2, 3, or 4. A random allocation was desirable to increase the likelihood of a mix of service representatives in each group. Depending on the numbers at the session, two of each number may be allocated to one group. I asked participants what they expect the barriers might be for the implementation of the information that had just been presented to them (see Appendix B). I then asked participants to discuss this amongst their group and scribed the discussion. I informed participants they could present this to the broader group if they wished. All groups chose to do so. As the researcher, I scribed this feedback verbatim. The lack of a formal structure enabled the development of rapport so that participants felt more at ease when discussing potentially personal information. In the results section, a labelling key is utilised to help identify the sources of quotations.

Given the support workers were present in this session and were discussing their experiences with restrictive interventions, I decided to seek confidential responses about their direct experiences of the use of restrictive interventions prior to breaking into focus groups.

At the beginning of the training session and prior to the focus group sessions, I handed out a list of restrictive practices to participants (see Appendix C). I invited support workers to indicate which practices they had witnessed in their organisation. I advised participants that they did not necessarily have to have performed the intervention themselves, but may have just witnessed it in use. It is likely that, if those practices were used, it would be those present at the session that would be utilising those strategies, as those people provide the direct support.

I advised participants that no identifying information was required, therefore it was not possible to determine who responded, and from which organisation. I also advised participants that no repercussions would be experienced through identification of practices, or for non-participation. Ninety-five out of the one hundred and ten participants chose to respond (these results can be seen in the next chapter, see Figure 5).

Due to the issues raised throughout the support worker focus groups, it became evident that the views of alternative stakeholders should be canvassed. Support workers raised issues associated with families and people being supported, as well as factors associated with the clinical teams within the department, all of whom may influence the ability to comply with legislative requirements. Accordingly I held additional focus groups with those clinical staff.

I sent an email to the managers of each of these four clinical teams within DHHS, seeking interest in participation and some possible dates for a focus group. Together we identified and arranged a suitable date for the North and North West and the two southern teams selected a date and attended together. Thus, three focus groups were held. I used the same questions in the clinical focus groups and support worker focus groups (see Appendix B). I recorded these focus groups using a digital voice recorder.

(c) Interviews

Given there was only one response from an advocate and she worked in a different region, I interviewed her over the phone. This interview time was made via email correspondence enabling a mutually agreeable meeting time to be made. This interview was recorded with the consent of the advocate.

Similarly, given there was only one family member who agreed to participate in the research, a mutually agreeable time was made via the advocate who had identified this family members willingness to participate. This family member attended an interview at the University of Tasmania Clinical School. Both research supervisor and researcher interviewed her. The same questions were used for this interview as for focus groups and above interview, however for a variety of factors this interview took a tangent towards some information that was not necessarily relevant to restrictive interventions in the disability sector, but in other agencies of the Tasmanian public sector. Prior to the commencement of open-ended questions, I outlined the specific nature of the study. That was, I was interested in the regulation of restrictive interventions and the aspects of the Act relevant to this. Once this was established the questions were asked. Those questions were: (1) what are the benefits of legislation such as the Disability Services Act; (2) what are the disadvantages; (3) do you see there have been any barriers to the implementation of the Act; (4) what are these, if any; (5) how might these be overcome.

This interview was recorded with the family member's consent.

(d) Written correspondence

At this stage of the study, it had been some time since the proclamation of the new Act, and nearly twelve months since the initial survey to the leaders of organisations. Given that the focus groups were indicating difficulties implementing legislation from the workers' perspective, I was interested in determining the level of measurable compliance with the legislation. I was also interested in determining whether organisations had related policy in place, whether they provided the training the workers indicated they required, and whether any restrictive interventions with or without approval were in place in their organisations. I wanted to ask the leaders of organisations a series of questions;

however, given the poor response rate to the initial survey, a different methodology was required. Given the number of organisations to be surveyed, it was not possible to meet with all of the leaders separately. Therefore, a written letter was sent to each funded disability organisation.

I emailed this letter to all contacts (22 November 2013) requesting a written response to the letter by 30 January 2014. Upon conclusion of that time frame, I collated the responses and generated a list of any outstanding responses.

Four organisations responded indicating the questions were not relevant for their service, for example, they did not provide direct support to people. I therefore made an assessment of each organisation's relevance at this point. Again, I made this assessment with the assistance of a senior project officer within Disability Services, who has a good working knowledge of the organisations and their core business. I decided that forty-seven from the seventy six organisations were relevant and therefore continued to be pursued to provide responses.

Those outstanding responses from relevant organisations were sent another request (24 February 2014) to respond, and I gave a two-week deadline. After this deadline, there were still fifteen responses outstanding, I sent another reminder specifically addressed to these organisations (6 March 2014) with response required by 22 March 2014.

At this deadline, there were still fifteen responses outstanding, including two from large organisations. The other organisations were defined as non-responders (thirteen) and not pursued due to the fact they supported very small numbers of people. The Deputy Secretary of Disability and Community Services contacted the CEOs of these large organisations individually, again giving another deadline. This letter (see Appendix G) emphasised the importance of this request and their response. The day before this response was due, as nothing had been received by either organisation, the department's contract managers contacted the larger organisation and requested a response. The contract managers were used in this circumstance due to existing relationships with these service providers. Both of these organisations made contact in the couple of days following. The timeframes for those requests is shown in the flowchart over.

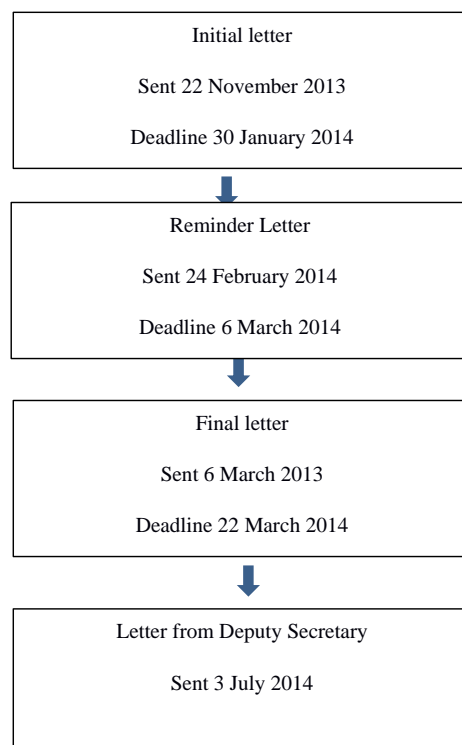


Figure 2. Flowchart for compliance letter timeframes

I initially forwarded this letter to representatives from the seventy-six state funded disability organisations. This target group was the same as the group surveyed in the initial survey. I assessed the letter as relevant to forty-seven of those seventy-six organisations.

When I received a response, I categorised the organisation by size (number of people with disabilities supported by the organisation) and collated in the corresponding size category. Categories were as follows: those organisations that support less than twenty people (small), those who support twenty to forty (medium), and those who support more than forty (large). I determined these categories from data received by the department, which showed the amount of people each organisation supports.

Throughout the discussions thus far, participants had described the role of the clinician in the implementation of strategies to help reduce the use of restrictive interventions. In addition, from my role as Senior Practitioner, it became increasingly clear there that were varying levels of knowledge amongst the clinical team about the Act and their role in the implementation of the Act. Team members are expected to assist organisations seek alternatives to the use of restrictive intervention, for example, through the use of BSPs, yet it was becoming increasingly evident that many members of the clinical team members had no formal training in this area. In order to determine whether these teams required additional training, or if there were elements of the Act that were not clear for them, I decided to survey those clinical team members.

(e) Written survey

In order to maximise participation in this survey, I developed a minute (formal departmental communication) addressed to senior managers to help ensure that the various agencies were in support of their staff completing this survey. I circulated this to senior managers, seeking their endorsement of the survey. I believed if these managers endorsed the survey, they might be more likely to emphasise the importance of it to their staff. The dissemination was approved by senior management. The survey was discussed at a meeting of departmental clinicians, as well as at a departmental reference group that included members of those clinical teams. During these forums, the rationale for the study, parameters, and confidentiality was discussed in detail. I packed an envelope containing a reply paid envelope, the survey, invitation, information sheet and consent form. I sent an unidentified copy for each team member to the aforementioned group member for dissemination amongst their team. I also sent an email to the team members informing them of the survey. The team managers requested a one to two week turn around. When members completed their survey, the instructions given via email directed participants to place it into replied paid envelope and send it to the researcher. Three responses were received in the first week, and four in the second week.

As only seven responses from a possible thirty-eight were received at this stage, a follow up email was sent. With a total of eleven responses at the end of a four-week period, team managers were contacted directly about possible reason for poor response rates. They were asked about the potential reasons for this, and whether any action might increase the response rate. Team managers reported that some staff stated they did not have time, and others stated they felt as though their knowledge was being questioned by the survey and therefore did not feel inclined to respond. One person reported not completing the survey because one of the questions asked for any training requirements around increasing knowledge of the Act. This clinician stated that they didn't have time to attend training, therefore had not completed the survey.

Data Analysis

(a) Online survey

In this study, the online survey was conducted through "Survey Monkey" software (<http://www.surveymonkey.com>). I analysed the responses through the use of inbuilt processes within this package. I generated question summaries that showed overall results. Results to open-ended questions were also generated by the software, which was a collation of information provided by respondents. I exported the data to Excel to develop graphs and tables.

(b) Focus groups

Support workers

During the course of the focus groups, participants discussed the Act as it relates to the regulation of restrictive interventions and any barriers they saw to its implementation, along with solutions they saw to help overcome these barriers. I asked each focus group to nominate a scribe who made notes about their discussions as the discussions were taking place. These notes were reported verbally to the larger group. During this feedback, I made verbatim notes about the discussion topics, and particular quotes from these discussions. A large amount of written information was generated from the focus groups. I conducted a thematic analysis of the material by reading, re-reading, and identifying various common themes that related to the research questions. That is: what are the barriers to the implementation of Disability Service Act; how these can be overcome; the advantages of such a legislative framework; and the disadvantages of such a framework; how might those be overcome.

The thematic analysis was conducted by initially summarising the overall issues that emerged from each transcription. I then went back over the transcriptions and colour coded each line if an issue was evident. I developed a code template (colours) to represent the themes identified in this initial analysis. In order to code the transcriptions, I made annotations on the transcript during each reading. Broad themes were identified in the first instance- for example themes of training; attitudes; skill. I then compared these for frequency across transcripts in order to develop a picture of more specific themes to add to the template, which I then coded on the transcriptions.

Following the coding of all the transcriptions, I re-checked the consistency of coding. This process was iterative, with reanalysis conducted across the material from all focus groups (support worker and clinical) and interviews. This step involved making sense of the themes identified, and making inferences from the data, as presented in chapter 4. This process of examining sections or themes and the whole of the documents by reading and re-reading ensured any new ideas and themes might be discovered.

This coding process involved: (i) identification of a coding template- colours for themes following the understanding of the data in the transcriptions; (ii) application of the coding template to the data; (iii) adding to coding template for themes emerging; (iv) re-application of the coding template until all themes and data was coded. This process acknowledges the active role I played in the collection of the data and then the analysis of the data.

The credibility of this data and themes was established through debriefing with the research academic supervisors in order to confirm interpretations.

The use of verbatim quotes has been used in the reporting of these for all focus groups and interviews. Quotes are taken from the transcripts relating to the main themes. A purposeful selection of these quotes assisted in highlighting the relevant themes. Guest, MacQueen and Namey (2012) argue that the use of verbatim quotes connects the researcher's interpretation to what participants actually said. The quotes from the support worker focus group are referred to in the results as "support worker focus group".

Clinician focus groups

I electronically recorded and then transcribed the focus group discussions. As described above, qualitative data analysis techniques were used to organise and code the transcriptions of these discussions. I then employed the same process of thematic analysis, as described above for the analysis of clinical workers transcripts.

I assigned each participant a focus group number and a participant number by which to be identified. These can be seen in Table 6.

I read each transcription five times prior to commencement of analysis. I identified themes on the fifth reading. I highlighted themes with differing colours, and wrote the theme in the margin of the transcription. I repeated this process with every transcript. I generated a list of themes following the analysis of each transcript and then matched the lists matched for recurring themes. Then, as described above, I analysed these themes in the context of themes emerging from other focus groups and interviews.

I described the themes by using verbatim quotes from the transcribed interviews. These themes are elaborated upon in the issues chapter. In the results labelling key, these are referred to as "Clinical focus groups".

(c) Checklist

I collated the responses (see example Table 3) of completed checklists. Each checklist response sheet was recorded in the table, and a sum of the number of references to the practice was tallied.

Table 3. Recording Table for checklist responses

Holding from behind by crossing a person's arms over their chest and restraining	Restraining a person to the floor face up	Physically escorting a person to another area while restraining their arms	Restraining a person to a chair or in a sitting position	Breaking away from grabs/attacks/kicks	Locking doors to prevent access	Containing a person within a certain restricted area	Withholding a valued item or activity to change a behaviour	Increasing supervision to change a behaviour or to minimise risk

(d) Interviews – Families and Advocates

I electronically recorded and transcribed these two interviews. I read these four times and then made an initial summary identifying the issues raised. I then compared those issues with the themes that arose from focus group interviews and included in the thematic analysis as described above. In the results labelling key, the interview with the family member is referred to as “family interview”. The interview with the advocate is referred to as “advocate interview”.

(f) Written Correspondence

I categorised organisations by size as I received their (number of people with disabilities supported by the organisation) then I collated into the corresponding size category (as described above).

I develop a table as follows for each of the three categories, small, medium, and large. I gave a numeric response for each question. For example, if a respondent answered “no” to question 1, a “0” was scored. If answered “yes” a “1” was scored.

Table 4. Recording table for organisational responses.

Organisation name	Question 1 Yes	Question 2 Number	Question 3 Yes	Question 4 Yes	Question 5 Yes

Any qualitative data provided was also noted in this table.

I then converted the responses to percentages within the categories of organisational size; these can be seen in Figure 6.

(g) Written Survey

I collated the responses from each question under question headings (see table 5). Question 1 required a numerical response. I then collated the responses. These can be seen in Table 8.

I read questions 2-6 five times in order to identify common themes. On the fifth reading, I identified themes by colouring with different coloured highlighters. I listed the common themes and corresponding comments transferred to these lists. I attributed comments to respondent identification letter A-K. These responses can be seen in the Results Issues and Evaluation chapter (4).

Table 5. Recording table for clinical survey responses

Respondent	question						
	1	2	3	4	5a	5b	6
	Rating of training need 1-7	Area of training need	Example of environmental restriction	Example of personal restriction	Steps for use of RI	Steps for recommendation of RI	Risks of RI
A etc.							

Results labelling key

Table 6. Results labelling-focus group/interviews

Type	Group number	Labelling in results
Clinical focus group	1	1.1,1.2,1.3,1.4,1.5
Clinical focus group	2	2.1, 2.2, 2.3,2.5,2.5
Family interview	3	3
Advocate interview	4	4
Clinical focus group	5	5.1,5.2,5.3,5.4,5.5,5.6
Support worker focus group	sw1-13	sw1-sw13
Clinical survey	A-K	A,B,C,D,E,F,G,H,I,J,K

Table 6 (above) provides the labelling key for the results from the focus groups and interviews. The key to this table is as follows:

- 3 clinical focus groups were held. These are labelled group 1, 2, & 5
- 1 family interview was held

- 1 advocacy interview was held
- Quotations in results section will provide reference to the group member first and then the group number; for example, 4.1 is a quotation from member four of focus group one
- 13 support worker focus groups were held, each with approximately 6-8 participants in each. These are referred to by the number of their focus group 1-13, including the prefix “sw”.

Individual members of the focus group were not identified.

- Group 1, clinical focus group, 6 participants
- Group 2, clinical focus group, 5 participants
- Group 3, family interview, 1 participant
- Group 4 advocate interview, 1 participant
- Group 5, clinical focus group 6 participants
- Group 6, support worker focus group

Methodological and ethical considerations

Poor response rates were one of the main issues of this study. The responses to the initial online survey and the clinicians' survey were particularly poor. For example the response to the online survey was 22%. Responses to the written compliance letter also took a significant time to gather. It is possible that one of the main reasons for this poor response rate was related to the impact of my role as insider researcher. Perhaps people were reluctant to respond to these requests due to concern that their responses may lead to penalties under the Act. Regardless of the reason, it may be said the response rate is not sufficient on which to base conclusions.

It is difficult to draw conclusions from interviews where only one person participated, that is the advocate and family interviews. Ideally greater numbers in these interviews would add further qualitative information. However, the same thematic analysis was conducted with these interviews and any similar themes included in the focus group thematic analysis data. This is demonstrated through the addition of quotes from these interviews that highlight the themes.

I became aware that a general wariness was experienced throughout the course of this study. For example, clinical staff were reluctant to complete their survey due to a feeling (expressed personally) that they were being tested; representatives from community service organisations believed that responses were poor due to the perceived possibility of being found wanting; organisational staff were not allowed to speak freely at training sessions, due to what appeared to be a fear of what they might disclose. Therefore the accuracy of results and conclusions drawn from such low response rates may be questioned.

Some of the results were also clearly inaccurate. For example, CEOs represented staff as having a good knowledge of issues associated with the use of restrictive interventions, and also stated that this isn't actually true. Previous research in this area has found underreporting and inaccuracies due to social desirability (McGill, Murphy, & Kelly-Pike, 2009).

Given the absence of baseline data, and no previous assessment of attitudes, levels of training, and education, there may have been significant changes to these aspects since the proclamation of the legislation. Regardless of this, however, participants in the research indicated there were significant barriers to the implementation of relevant sections of the legislation, and few activities are in place to address this.

Methodological considerations of insider-researcher

Clearly I held a dual role throughout the course of this research: that of Senior Practitioner (insider) and researcher. There are key advantages to the position of insider researcher, for example having a greater understanding of the culture being studied, who best to approach and how. The nature of being an insider infers a 'feel for the game and the hidden rules' (Bourdieu, 1988 as cited in Floyd & Arthur, 2012, p3).

This unique position allowed me to have easy access to people and information which helped to make changes in my work-based practice and situation. However there can be limitations to studies as a result of an insider-researcher position (Unleur, 2012). In this study, this may be particularly so given my legislated role and the potential powers for penalty actions if organisations are acting in contravention of the legislation.

Data collection activities which required comment on compliance issues.

The data provided through the online survey, support worker checklist and written compliance letter may not accurately reflect practices taking place within organisations due to respondents potentially being concerned about my dual role. Respondents may have been wary of my role as Senior Practitioner and perhaps have formed a view that they or their organisation may be subjected to penalties if they revealed honest but unfavourable information for the purpose of this research. For example, leaders of organisations were asked directly if they had any restrictive interventions in place for which they did not have approval, something which may attract penalties under the Act.

Revelations of non-compliance made to the researcher were managed in a manner which was consistent with my role as Senior Practitioner. At this point in time I was taking a very supportive and educational approach towards organisations. Therefore organisations were supported through the

legislative process to correctly report practices. Assurances were given that a punitive approach would not be applied at this stage of legislation implementation. Some organisational representatives reported positive outcomes as a result of the research process. They had been provided with assistance they may not otherwise have sought.

Focus group activities

This dual role presents a risk for certain activities, such as focus groups, as a greater familiarity with participants may lead to a loss of objectivity. Unconscious wrong assumptions based on the researcher's prior knowledge may be considered a bias (DeLyser, 2001). This may be a limitation to this study due to my familiarity with clinical staff, who participated in focus groups. I may assume an understanding of issues raised and therefore less likely to seek clarification. My relationships with other focus group participants was not one of familiarity.

Such familiarity may also detract from the formality or perceived importance of focus group activities and therefore participants may not respond with as much detail as they would if someone unfamiliar were conducting the group. Participants may have assumed I understood the existing issues and therefore may not have raised them to the same extent they would were an outsider involved.

Some clinicians may also have felt more at ease given our familiarity and raised issues with the perception I would understand and accept these opinions without reprisal. Clinicians may also have had opinions about my professional role but felt constrained about revealing these. One method of addressing this was through the opportunity for anonymous comment later through the written survey.

Given I was cognisant of this potential for bias I ensured I checked, through questioning and rephrasing, that I had the correct interpretations of the statements and issues raised. It may also be the case that whilst I understand the broader culture of the disability sector, I am not an insider in specific subgroups within the sector; therefore I do not understand the subculture sufficiently to make assumptions.

General results bias

My role of insider researcher may have led to bias in interpretation of results (Unluer, 2012). To ensure interpretative rigour, a variety of differing methodologies were utilised. The inclusion of individual interviews, as well as survey methodologies, ensured that focus group members, for example, did not detect and conform to the researcher's point of view. In addition, in order to prevent any informant bias, I did not express any opinions throughout data collection; my interaction with participants was about clarification of their points of view. The process of refining, rephrasing, and interpreting information ensured that correct information about the recording was gathered and this could be interpreted accurately during the analysis. Given my psychology training and micro

counselling skills, this clarification of information in interviews and focus groups was effective. Research tends to be unclear however, whether insider or outsider researchers are more prone to informant bias (Mercer, 2007). As Rose (1985) stated “There is no neutrality. There is only a greater awareness of one’s biases” (as cited in Dwyer & Buckle, 2009, p77)

Participation consent

It is possible participants may have felt they were not able to refuse to participate in this research due to fear of work related consequences of non-participation. It is true there was a level of expectation of participation to the written compliance letters, as this was a requirement of the department. However, in terms of the other data collection activities, information to participants and invitation letters outlined there was no compulsion to participate or penalty for withdrawal. The clinical focus group requests and interview requests were sent clearly from me as a researcher using university stationery. The others were work based activities and no identifying information required- therefore it was not possible for me to determine who had responded and who had not. This was made clear to participants.

Organisational loyalty

This research reveals some criticisms of the Department of Health and Human Services (DHHS), my employer. My loyalty to my employer may have the potential to bias my interpretation of results and the manner in which these are detailed or commented upon. There were things reported which were detrimental to the organisation. This led to some conflict between my loyalty to my employer and the ethical aspects of the research. This was a process which was addressed through my ongoing academic supervision.

Chapter 3 in brief

Chapter 3 sought to outline the methodology employed in this study. Firstly, an outline of data collection activities was provided. The details of ethics approval was included, in addition to a description of the participants involved in this study. The procedures employed in the collection of data were outlined, and a description of how the data was gathered and analysed is given. Methodological considerations are outlined in this chapter. Chapter 4 will describe the results in more detail, including those results gathered from focus groups and interviews. These results are delineated in such a manner due to the amount of detail which was gathered through the focus group and interview methods, and the somewhat different information requested from these groups compared to that requested in the survey/written correspondence groups.

Chapter 4.

Results

Issues and Evaluation

Chapter 4.

Results

Issues and Evaluation

The previous chapter outlined the method for the data collection in this study. This chapter provides a collation of graphs and tables, qualitative and quantitative results from the specific data collection activities, combined with information gathered from components of exploratory research.

Figures & Tables

This section provides a summary of results represented in figure/table form. The results of the thematic analysis for these groups and interviews are included in “Issues and Evaluation”.

Online survey (CEO/Managers)

All funded organisations are required to have policy around the use of restrictive interventions. The numbers of organisations who have this policy will help to highlight the level of compliance with this aspect of departmental policies and procedures.

Figure 3 shows results from the initial survey sent to organisations. This figure shows that from those who responded, only forty-seven organisations have policy relating to the use of personal restraint, and only thirty-seven have policy relating to the use of environmental restraint. Figure 3 also demonstrates that more training is provided in techniques of personal restraint (about half of those who responded) compared to environmental restraint (less than half of those who responded).

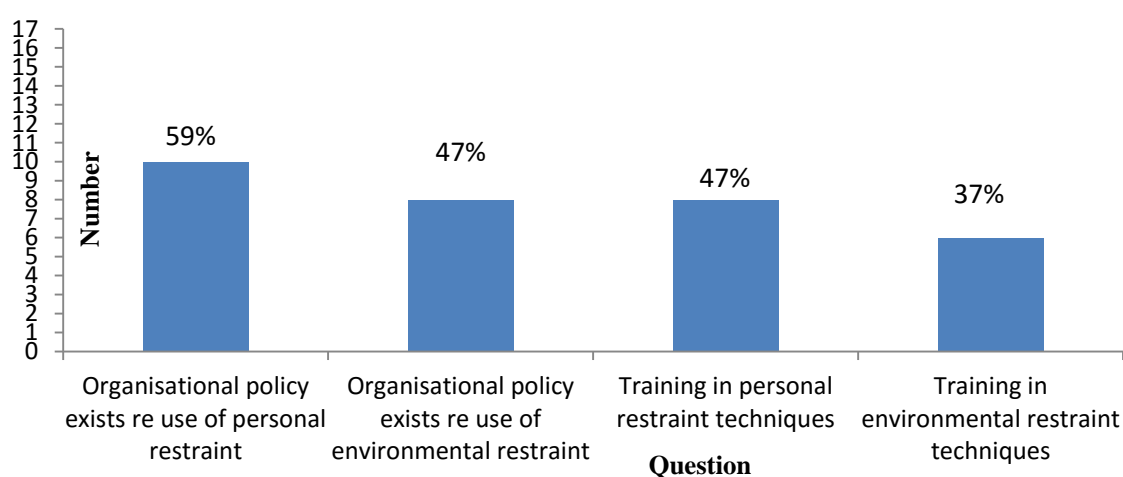


Figure 3. Number of organisations who provide policy and training to staff.

Through the online survey we asked organisations to report on the types of training provided to staff. This is to help determine the extent to which organisations have prepared staff to understand their requirements under the Act. These results can be seen below in Figure 4.

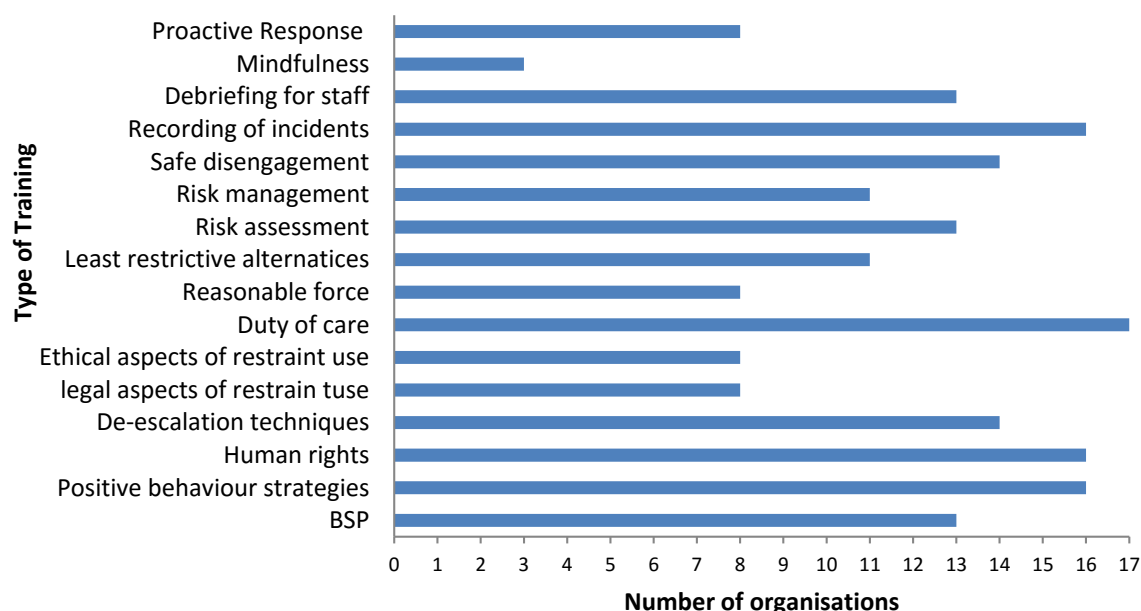


Figure 4. Type of Training provided.

Figure 4 shows that all of the organisations who responded train their organisations in duty of care. Only approximately half train their workers in the legal and ethical aspects of restraint use. Almost all organisations who responded train their staff in issues associated with human rights and positive behaviour support strategies.

In a further section of this survey we asked CEOs or equivalent to identify how many funded service users had BSPs which outline the use of restrictive interventions. This question is relevant as the literature review highlights, because the use of restrictive interventions should only be utilised as part of a behavioural support plan, designed to eventually reduce the need for these interventions. Table 7 shows the number of service users who have plans which outline the use of restrictive interventions. Those who responded with “0” either had no restrictive interventions in place, or had restrictive interventions in place with no plan.

Table 7. Numbers of service users who have support plans including the use of restrictive interventions.

Respondent Organisation	Number of plans
1	1
2	2
3	0
4	0
5	6
6	0
7	2
8	Unsure
9	6
10	0
11	2
12	0
13	0
14	0
15	0
16	5-8
17	4

Table 7 shows that only approximately twenty eight to thirty one people supported by Community Service Organisations (CSOs) have plans that outline the use of restrictive interventions. Of significance is that some respondents were generally unsure, or unsure of exact numbers. As the Senior Practitioner for Disability Services, the use of restrictive interventions requires application to me for approval recommendation (or otherwise). At the time these results were provided, I had seven current applications for approval of the use of restrictive interventions. Therefore, twenty one to twenty four restrictive interventions did not have approval for use.

Support worker checklist

When we asked support workers to identify if they had witnessed any of the potential restrictive intervention types listed, ninety-five workers provided a response. Those responses can be seen in Figure 5. Figure 5 shows that the most commonly observed intervention types were those of increased supervision (twenty-three percent) and break-away techniques. There is a relatively high rate of locked doors witnessed within the sector (twenty-one percent). A very low rate of floor face up restraint was reported, with only one percent of respondents witnessing the intervention.

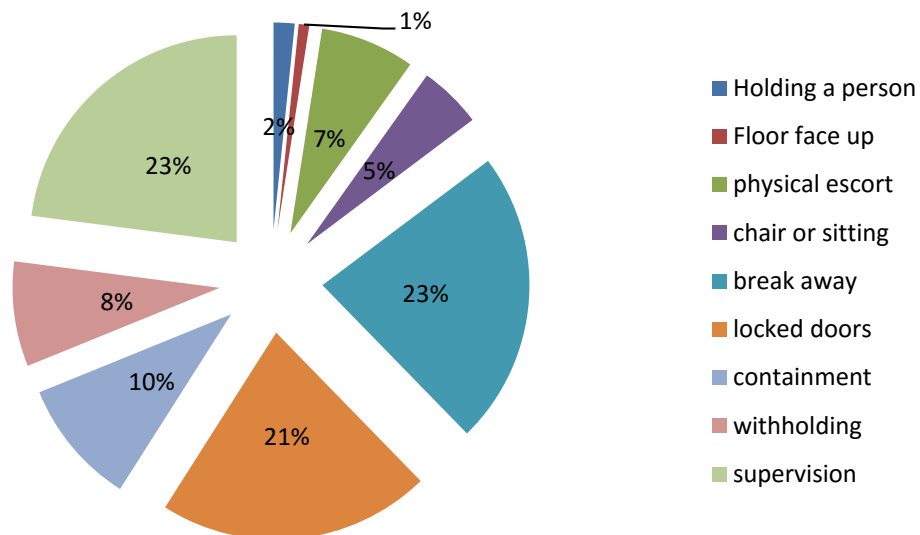


Figure 5. Numbers of support workers who have witnessed differing intervention types.

Written compliance letter (CEO/Managers)

We asked the CEO's (or equivalent) questions in relation to the use of restrictive interventions in their organisation. The questions sought to determine the level of compliance the organisation exhibited- that is, the number of interventions which had approval for use, compared to the number in place. In addition, the letter requested information about the existence of organisational policy. The questions also enquired about training provided for staff, and whether those leaders and managers believed that their staff had an understanding of the issues associated with the use of restrictive interventions. The results of this are shown in Figure 6.

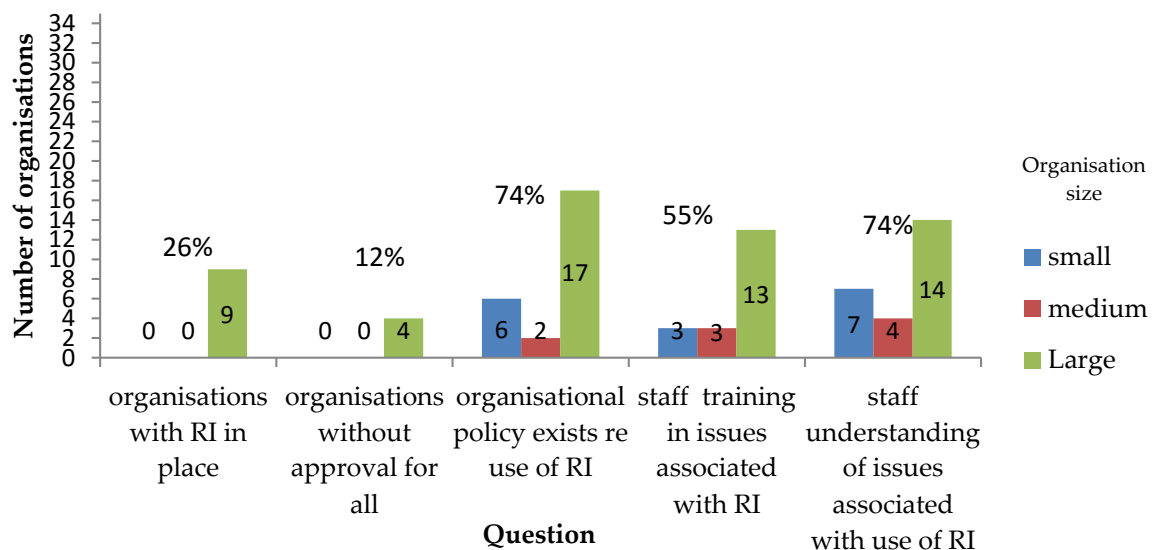


Figure 6. Organisational responses to survey questions- percentages of total responses

These results show that twelve percent of the organisations who responded are working in contravention to the legislation; that is, have interventions in place without approval through the Act. Approximately seventy percent of CEOs thought the staff in their organisations understood the issues associated with the use of restrictive interventions. Interestingly, only around half of organisations provide training for staff in this area (fifty-five percent). Around seventy-four percent of the organisations who responded reported the existence of policy associated with the use of restrictive interventions. Additional analysis of results shows of those nine organisations that had plans in place all had developed policy in relation to the use of restrictive interventions.

Clinical Team survey

We asked departmental clinicians a series of questions, including their individual need for additional training and education around the issues associated with the use of restrictive interventions. The results of this can be seen in Table 8.

Table 8. Survey results- need for further education and training

Scale	Scale descriptor	number of responses
1	no need	0
2		0
3		4
4	some need	3
5		1
6	strong need	5
7		0

These results indicate that clinicians see the need for some further education and training in aspects of the Act and operationalisation of the Act. The greatest number of clinicians choose the “strong need” option on the scale.

Issue and evaluation

How much are restrictive interventions used?

The issue of reduction of the use of restrictive interventions is only relevant if restrictive interventions are used within a sector. This has previously not been measured in Tasmania, so it was important to determine participants' perceptions of the presence and extent of the use of restrictive interventions. Consistently, participants identified that restrictive interventions occur within the sector. Clinical focus group participants gave examples:

“They weren’t able to move the wheelchair as a punishment for bad behaviour.” (4.1)

“Locking gates, locking refrigerators, taking handles off doors, locking doors...” (5.1)

“Yeah...I would say its psycho-social restraint, it was something about their relationship and I guess the problem was that the staff hadn’t intervened, they hadn’t recognised that it wasn’t fair and they hadn’t intervened to change that...” (2.2)

“I had an incident the other day with a client where she was dragged by the ankles into a room and her bedroom door deadlocked and called time out. That’s not time out. That’s assault. It’s just assault.” (5.2)

The rate of use of restrictive interventions in the learning disabled population is estimated be about ten percent (Lowe et al., 2007). The most reliable Australian figures come from Victoria, and similarly reflected a rate of approximately nine percent in 2007; however this has been decreasing since interventions were implemented (Webber, McVilly, Stevenson, & Chan, 2010). In Tasmania in the 13/14 financial year, there were twenty-seven approved applications for use of restrictive interventions. In the same year, there were six thousand, five hundred and forty seven service users (NMDS). It is not possible, however, to ascertain a percentage of service users being subject to restrictive interventions. Currently, the Tasmanian system relies on organisational reports of use of restrictive interventions and this depends upon their wiliness to report, their understanding of definitions and so on. It is expected the accuracy of this percentage will improve as the implementation of the relevant sections of the Act becomes more effective.

During one information session, support workers from several different organisations were asked to identify from a series of practices those they had encountered within their own organisations. Relative to the other types of interventions listed, high rates of locked doors and supervision were reported (thirty-nine & thirty-eight percent respectively). Containment and withholding were reported in sixteen and fourteen percent of respondents. Holding a person and using prone restraints were

quite low, being reported at three and one percent respectively. Whilst it is unclear how many organisations were represented, this provides an indication of the relative use of interventions in the sector.

It was considered by the majority of focus groups, there was a greater awareness amongst the sector of restrictive interventions, and examples of their use since the new Act was proclaimed were identified. This awareness raising is seen as the first step to the implementation of the new Act, and addressing alternatives to the use of restrictive interventions. This greater awareness is identified by a clinical focus group participant:

“...it’s sat in somebody’s filing cabinet and it has filtered down to the workers. But this year’s sessions people were actually aware that they might not have been aware of the concept, but they were aware that these things existed, which I thought was pretty good.”
(1.1)

The Act defines two types of restrictive interventions, personal and environmental. Clinical members of focus groups indicated that restrictive interventions might often fall outside these definitions, be less overt, and sometimes lie in the attitudes of those supporting people. These circumstances may therefore be more difficult to quantify and monitor. The focus group's discussions about this, and the issues around definitions under the Act, led to a discussion about how these definitions need to be examined closely and extrapolated for operational use. This clinical focus group discussion identified that some measures may indicate services are working well; however, once the surface is scratched, this may not be the case in terms human rights.

“As long as the bandages are clean and people are well dressed and they’re relatively smiley and friendly then everything is hunky dory.” (sw 5)

The following are a few examples of less obvious practices that might be considered restrictive that were raised by clinical focus group participants:

Lack of meaningful activity:

“...day support is somewhere where you come and sit and park in the corner until you go back to your hotel room and that’s what it’s like.” (2.1)

“In day support we’ll start to see a lot of restrictive practices. Not in the sense that they’re forcing people to do something against their will but there’s a lack of innovation and

creativity in day activity. So, people will just be put in a group in a day support centre and left. There's no thought to what are this person's needs, what skill can be developed, how can we make their life more interesting and rich." (5.1)

Removal of means of communication:

"...taking away communication devices because the staff don't understand." (5.1)

It is clear that some advice regarding the operational translations of the definitions outlined within the Act is required to determine where these issues fall. Without this clarity, it is difficult to determine a true picture and compare across jurisdictions as their definitions are different. It is the intention of the service system, once National Disability Insurance Scheme (NDIS) is fully introduced, to have consistent national definitions, as well as consistent systems for recording and monitoring the practices.

Managers and Leaders

A review of the literature highlights how important it is that the leaders and managers of organisations assist in the reduction of the use of restrictive interventions. Overwhelmingly, members from support worker and clinician focus groups raised the necessity of involvement of leaders and managers in assisting to implement the requirements of the Act and reduce the amount of restrictive interventions in services.

Management of direct support staff

Support worker focus groups highlighted the need for managers and leaders to act on views of support workers who are on the ground, and to hear their issues in directly supporting someone who might be exhibiting behaviours of concern. For example, when discussing their need to raise issues with their managers and leaders, one support worker said [about managers]:

"Often they don't hear." (SW 6)

This statement was made in the context of support workers sometimes needing to justify the need for particular practices, or additional resources to help manage a behaviour of concern, in a way

that is acceptable under the Act. It was thought that managers and leaders sometimes didn't understand these issues or listen to the support workers' points of view.

Support worker and clinician focus group participants indicated that the strength of this leadership was sometimes in question, and differential levels of commitment to areas such as best practice were evident. There was a common theme, that managers were instead focused on financial management. One clinician stated:

“Staff are supported by very weak management...because management is more about finances now rather than caring.” (2.1)

The view of participants in this respect is supported by the finding that only approximately one third of organisations provide training for staff in the issues associated with the use of restrictive interventions, despite the fact that these issues are directly related to legislative requirements.

A view commonly expressed by clinical focus group participants was that, although it was the direct support staff who predominantly used restrictive interventions and practices not consistent with best practice, it should not be these workers who are always held accountable, and that management plays a large part in ensuring that their organisations are compliant with the legislation. One support worker in their focus group expressed their concern for accountability around the behavioural management:

“We need managers to be committed and accountable.” (SW 10)

Need for Organisational Policy

A significant number of focus group participants from both the support worker and clinician groups said they thought that managers and leaders of organisations needed to develop organisational policy that is consistent with the spirit of the Act, so that support workers were clear about how they were expected to support people. That is, restrictive interventions cannot be used, positive support practices needed to be employed, and so on.

The analysis of responses (see figure 6) from the letter sent to the leaders of organisations found that around half of large organisations (fifty percent), only six percent of medium, and eighteen percent of small organisations have restraint related policy. It is understandable that direct support workers were expressing the need for greater policy direction from their organisation. Williams and

Grossett (2011) demonstrated that the use of organisational policy and goals for reduction of use of restraint was very successful.

Focus group participants emphasised the importance that this policy be operationalised and filtered down to those in direct support roles. Focus group participants, both support workers and clinicians, said they thought that leaders and managers needed a greater understanding and emphasis on the way in which someone was supported in accordance with principles of the Act, not just what might be easiest for them as managers. For example, one support worker said:

“The organisation needs to develop practice and policy that are consistent with the ethos of the Act.” (SW 10)

In the context of discussion about whether the leaders of organisations were up to date with the requirements of the Act and whether this had translated into operationalised policy, one clinician stated:

“From an organisational level, I think – I wonder where their policies are at around restrictive practices, around whether they had them in the past, whether they’re now in line with the new Act, whether they need to bring them up to date with protocols as well, so that staff do have clear ideas and pathways when they see restrictive practices, what do we do about this?” (5.3)

Managers' and Leaders' level of understanding

The extent to which the attitudes of a CEO may impact on those of the organisational staff were seen as significant by study participants. Participants considered it important for managers to understand the issues in order to impart these understandings to support staff. These findings are consistent with those reported in the literature. Leadership is one of the factors that leads to the successful reduction in the use of restraint (Maguire, Young, & Martin, 2011; Deveau & McDonnell, 2009; Rimland, 2011). Similarly, a strong organisational commitment has also been shown to reduce restraint (Sanders, 2009). Strong organisational commitment includes participation from every employee.

CEOs generally reflected an understanding amongst their staff about the issues associated with the use of restrictive interventions and their requirements under the Act. However, misunderstanding was often evident in more detailed responses forwarded by the CEOs. For example, when asked: “*does your organisation provide training for staff regarding alternatives to the use of restraints*” one organisational leader responded with: “*no, as restraints are not used here at xx*”. This

shows a lack of understanding as training would typically be provided whether or not restraints were used. It is usually understood that training is provided so that workers are supporting people in an active, person centred, positive manner in the best interest of their quality of life and human rights.

The case study below demonstrates how lack of understanding on the part of leaders can allow unlawful practices to exist in an organisation. The case study exemplifies the punishment of a person with a disability, for a behaviour interpreted as negative by the organisation.

Case Study: CEO understanding

A leader in one of the state's organisations was contacted by the Senior Practitioner following allegations made by a member of the public, regarding abuse occurring within the organisation. The Senior Practitioner investigated the complaint due to the description of the abuse meeting the definition of a restrictive intervention.

The person was locked outside their own home in response to outburst behaviour. The alleged abuse appeared to meet the definition of seclusion.

It appeared more than one person had witnessed the seclusion, on different occasions.

When investigated by the Senior Practitioner, it was evident the leader of the organisation did not understand the definition of restrictive interventions. It was his opinion that secluding someone for the purpose of behaviour control was not restraint, but an acceptable "consequence" of "bullying" behaviour (their words) that needed to be implemented in order to teach this person how to live independently in the community. The concept of consequences for behaviour of concern in those living with disability is a very out-dated concept that is contrary to their human rights and the spirit of the Act.

Seclusion is considered to be a restrictive intervention according to the Tasmanian definitions as well as those used in other jurisdictions. It is highly unlikely someone trained in the area of disability, positive behaviour support and the functional analysis of behaviour, would label a behaviour exhibited by a person with a disability under these circumstances as "bullying".

Definition information was included in the survey disseminated, in order to determine CEO's understanding of definitions. When asked to outline their understanding of the definitions of "personal" and "environmental" restrictions, most of the seventeen survey respondents showed a reasonable, albeit brief understanding of the definitions. However, one CEO responded "*we are not sure what you mean*". Many responded with limited responses such as "*locked doors*" and "*behavioural control of a client*", whilst another CEO responded with a relatively thorough description: "*personal restriction in the context of DSA 2011 relating to a person with a disability means a restrictive intervention requiring full or partial physical contact with the person to control their behaviour or any action that restricts the liberty of movement of the person- includes blocking or use of restraining harness, straps etc.*".

This brevity may be due to the method of collecting this information; that is, an online survey. People may have thought they needed to be brief, or perhaps this is all they had time for. It may also reflect a lack of understanding of the definitions. Clarity in definitions helps to minimise the use of restraint in human services (Rimland, 2011).

Focus group participants considered it important for the managers to attend training in order to increase their awareness of these issues.

“One of our key aims was to get managers to the training because they always say they’re too busy to come to training, but they needed to be there....we’d encourage them all very much to be there with their staff, to understand where we were coming from.” (2.3)

“But I mean, for day to day practice the manager should be sorting out the bits of the Act that are relevant and making their people aware of them because there are some that can trip you up and some that you have to comply with. The managers should be aware of the implications of compliance or non-compliance with the Act. They should be communicating the bits that are relevant to their support workers. I mean that should be a management function, shouldn’t it. To keep your workers safe. If you’re legally obliged to work within an Act, then I would think it’s the manager’s job to inform the support workers which bits they’re likely to trip over really. It’s not the support worker function to find out themselves, because they don’t know.” (1.4)

Ensuring compliance

An analysis of responses collated from the letter to the CEOs of organisations found twelve percent of organisations do not have approval for the use of all restrictive interventions they have in place (Figure 6). This is supported by information provided by organisations in the first online survey conducted. In reality, this means those organisations could be charged with non-compliance under the Act. The Act states this civil charge attracts a penalty of two hundred units (one penalty unit currently one hundred and forty dollars in Tasmania). This may indicate CEOs of organisations do not fully understand they may be penalised under the Act for non-compliance; otherwise, they might ensure all interventions were compliant. Alternatively, they may consider it unlikely they will be penalised. This may be due to a perception the department’s quality and safety framework lacks influence. It is indeed the case Disability and Community Services has no procedures in place to enforce such penalties, and has never done so.

It may be the case that a data collection method such as the RIDS system used in Victoria greatly assists with the management of organisations and insurance of compliance. This online data

collection system allows organisations to make electronic reports of their use of restrictive intervention- either planned or emergency reports. It is likely the use of this system allows data comparison and tracking with greater accuracy and efficiency.

Twenty-eight percent of CEOs /similar did not respond to the letter directed to them on three occasions, and many did not respond to the initial online survey. When staff from one of these organisations attended an information and education session, they made the comment “Oh dear you won’t want to come to our organisation!” and went on to say that a lot of the practices discussed as being in contravention of the Act existed within that organisation. This perhaps indicates that staff are aware they are being non-compliant, and perhaps the reason the CEOs did not respond was to avoid the issues. Alternatively, this may indicate that CEOs are not aware of the practices that occur at the support level.

Below is a case study that demonstrates how the knowledge of a CEO can benefit the reduction of use of restrictive interventions. The organisation below had restrictive interventions in place when the act was first introduced, however with the support of their CEO, worked to remove these restrictions.

Case study: A CEO ensuring compliance



Reduction of Restrictive interventions at V

The CEO of this large organisation independently gave his staff the direction to audit the use of restrictive practices within the organisation.

As a result of this direction, the staff attended an information and education session conducted by the senior practitioner aimed at informing the sector about the changes in the new Act in relation to the regulation of the use of restrictive interventions.

Following this training, the middle management staff met to discuss definitions and any practices that existed in the houses for which they were responsible. They documented these practices.

Next, they met with house staff and charged them with the responsibility to determine if any practices existed within the homes, and a spread-sheet was developed. Each of these practices was discussed between staff and middle management staff- some of whom have Institute of Applied Behaviour Analysis (IABA) training, to help determine if any alternative, non-restrictive practices could be implemented. At this point it was identified some of these practices were in place for therapeutic reasons or reasons of safe transportation, therefore this paperwork was identified and sought if not on file.

The organisation requested a meeting with the Senior Practitioner who sat with middle management staff to go through the spread-sheet and determine if any practices required application for use of restrictive intervention. The organisation had one practice in place that, if continued, would require application for approval. After careful consideration and with direct support staff input, this restriction was removed through manipulation of the environment to better suit the skills of the person.

Some practices were considered by staff to be restrictive, however would not meet the definitions outlined in the Act. Staff worked with the guidance of supervisors and middle management to seek alternatives to these interventions, where appropriate. This was achieved through a culture of person centred active support that is inherent in the organisation. Most of the staff have been trained in these frameworks and the organisation's plan is to ensure all staff participates in this training.

The organisation has no restrictive interventions in place. They do have some practices in place that are deemed therapeutic or for reasons of safe transportation- all documentation has been provided to explain why these practices are in place.

Governance

Model of Service Provision

An integral aspect of the NDIS will be the quality and safeguards implemented to protect members of the scheme. Included in this is a framework for the regulation of restrictive interventions. This requires adequate systems of governance. This study showed the Tasmanian service system exhibits current difficulties in adhering to systems of governance. This may have implications for adhering to a national system of regulating restrictive interventions.

Many participants in the focus groups and interviews expressed the idea that whilst CSOs at times do not provide an adequate service, this is not necessarily the responsibility of services, but rather the responsibility of the DHHS who ultimately governs the services. They expressed the idea that perhaps the governance over the quality of organisations was not adequate to shape service provision and monitor quality.

Recent KPMG reform recommendations led to the service system change which saw the department out-source services, so it was no longer the provider as well as funder, but it remained just the funder and governor of services. Focus group participants discussed this issue of governance at some length. One clinical focus group discussed the fact that they, as clinicians, often complain about the service provision of the CSOs. As one clinical focus group participant stated in the context of a discussion about basic services provided:

“...because some of these organisations are dodgy.” (2.2)

However, participants went on to discuss the fact that the department does little to outline what is expected of CSOs. One participant stated:

“It is surprising that there isn’t a formula for running a group home. You know a checklist ...there’s no formula which there could be quite a simple formula for keeping on top of all this stuff...we’ve never given them an explanation on what to look for...how do you have quality control over something that you haven’t got a statement about what it should look like. How do you do that?” (2.3)

One clinical focus group discussed the idea that services were not planned well but have simply evolved in an unplanned direction. In the context of this discussion, the same participant as above commented:

“Sometimes I think a lot of things in disability evolved from people’s good will. A lot of support agencies were started up by parents, you know. RSID which is now Devonfield was

started up by a group of parents who needed a home for their kids with disability. Multicap was the same and so was Giant Steps. It was family driven and so then these entities have not caught up professionally with the structure of the big industry. And so I think that's a lack and you can't then do all that sort of sound model and KPI work and outcomes because that's so dependent on really structured education of what's expected and that sort of thing. So it's about catching up a bit I think too for these places as well on that whole concept.” (2.3)

When discussing the quality of service provision and who is responsible for improvements in this, another clinician made a similar comment about the issue of lack of planning right from the start-that was deinstitutionalisation:

“It's interesting because I was around in 2000 when the [unclear] people jumped into accommodation but I think there was never any global planning of what the system would look like. Never any global planning, never any sort of concept of what happened when people got older, without day support model, not any concept about when they got gravely ill what the concept was. It wasn't any preplanning for any of that and I still see it in new homes that are put together, new clients coming in, there is no pre planning and there is no planning for a continuum of a future life in the houses” (2.4).

Similar discussion took place in other clinical focus groups with members identifying that planning and rigour was required for an effective service, not just money:

“...maybe because this idea exists that if you get money there it will work out. It doesn't work out.” (5.2)

Clinicians in focus groups also raised the issue that Tasmanians have close proximity to senior government personnel and this is often the driver of the way the department operates and how services are shaped and evolve. That is, it is easy for a Tasmanian to hold audience with senior government personnel, who may become involved in directing resources. For example, if a family is particularly vocal and is likely to complain, there may be additional efforts to provide service to this person, rather than overall services being well planned and governed. This view is stated by one clinical focus group member:

“There's nobody –I don't think there's anybody within the department that actually understand what best practice is within this area. They just really-it's all so heavily weighted towards protecting the minister, because that's part of our job which is a very important part.

But if you go back and look at the literature, they say poor services cost just as much as good services. In Tasmania they spend so much money on poor services ...” (5.2)

“Perhaps they [good services] do [cost more] but if you’ve had no qualifiers of that, no evaluation of it, we’re only guessing that they cost more.” (5.1)

Commitment to Governance

There was discussion amongst the clinical focus groups about a perceived reluctance on behalf of the department to act or impose penalties for poor service provision. Similarly to the above comments, one clinical focus group member proposed that whilst a ‘good’ service was difficult to quantify, there also appeared to be no commitment from the department to improve the quality of care. As one participant outlined, there is a lack of processes put in place following the changes brought about by the KPMG reform that defines the new relationship between DHHS & CSO’s:

“...it seems like a contracting issue...when we contracted out we’re not clear on what we expect of them to do and what we expect us to do, that we expect the partnership to do.” (1.2)

Similarly, a participant in another group stated the issue was associated with the commitment to contract management

“...so they’re not getting the best quality care right now. It is very difficult to quantify. There’s no certainty at the moment, no mechanism to correct that. The department’s certainly not bothered by it at all. There’s not a real commitment. I don’t think there’s a real commitment to improve care within the department anyway. It’s all lip service. They actually respond to the human rights in a nice written policy document and then they actually blame the support workers, where it’s all middle management. Like you said, community partnerships team are very effective people or whatever, but the actual standardised document they’re the worst they’ve ever been in the last 17 years. Shocking. The lack of thinking, the lack of input. It’s just once again; it’s useless at the top where you make the decisions. I’ll make sure my hands are clean and then I give unplanned, unskilled, poorly isolated people and we spend a lot of money and achieve poor results. That’s all we’re doing...I don’t know what’s happened now but even talking to people from local services when they say to you, we want to know because we could lose the contract. Where’s the bait? Where’s the teeth?” (5.2)

The discussion regarding human rights relates to the changed philosophy in the Act, which gives it a broader human rights focus. Operationally, this translates into a reduction of use of restrictive interventions as well as active support and person centred support. These comments suggest those changes need to occur at the middle management level and filter down to support staff. This comment also suggests it is the DHHS's responsibility to ensure the middle management is responding to the changes within the Act and that current documentation and procedures are inadequate for this purpose.

Support worker and clinical focus groups all raised this question about the government's commitment to the reduction of use of restrictive interventions given that the Office of the Senior Practitioner contains only one person. At these focus groups, it was discussed that greater resourcing would lead to greater efficacy with practices and assistance for the sector. As one clinical focus group participant said:

"A duplicate of you would be good because there is so many times I want to bounce things off you or an assistant or someone who's got your knowledge and skills and I know how flat out you are. That's frustrating I'd love you to have a couple of assistants so that I had someone else to go to." (2.1)

A rigorous system of governance may ensure that all those people with restrictive interventions in place have approval for these restrictions. As Figure 6 shows, twelve percent of organisations do not have approval for all of their plans. This percentage comprises only four organisations, as reflected in the results; however, in practice, this number is actually much higher. This is evidenced by the amount of applications or contact that has been received since the dissemination of the letter to CEO's. For example, one organisation sent through a notification that there were thirty unapproved practices in place in that one organisation and that most of these had existed prior to the implementation of the new Act. This was not reflected in this organisation's response from their CEO, which stated that no restrictive practices were in place, but suggests that the response served an educative purpose for the CEOs or an impetus to look further into organisational practices.

Under the Act, a new function is identified for some departmental personnel. That is the role of authorised officer. These trained people will have the power to enter premises where it is thought practices may exist which are in breach of funding agreements, or place a person with a disability at risk. The advocacy interviewee was of the view that if people knew about authorised officers being named under the Act; this would be useful for reasons of security, and the increased probability of people being compliant:

“I know you don’t advertise it for good reason, but I think it would be useful for people to know I’m just trying to think-power is not the right word-but that you’re able to investigate and go into people’s houses and things.” (SW 4)

The reality is, the authorised officer program is not yet functioning, three years since the proclamation of the Act, although some level of auditing is in place through contract management and the quality and safety teams. For example, to date, three organisations have contacted me as the Senior Practitioner following instruction from the quality & safety team. This instruction has identified the need for further investigation into the potential use of restrictive interventions.

Throughout the course of professional practice, it has also become evident that other aspects of the Act are not monitored through rigorous governance systems. For example, in spite of personal plans for people supported is mandated under the Act, some organisations have stated they do not have plans for all of the people they are supporting. This is in spite of educative work conducted by the National Disability Insurance Agency (NDIA) around writing personal plans. Adherence to aspects of the Act appears to be assumed, and not rigorously tested through strong governance systems.

Governance under the National Disability Insurance Scheme

When the full NDIA scheme is implemented, if it goes ahead as planned, the state government will no longer fund services. This will mean the state governments will not regulate or monitor the quality of services. Both support worker and clinical focus group participants raised concerns about the monitoring of services in this new system. Several participants also noted they believed that the state government did not do a very good job of monitoring the quality and standards at the moment, and many feared the situation would worsen under a new scheme, with more services and less proximity to those services. Throughout this discussion, one clinical focus group member asked:

“The NDIA becomes more pervasive and then it takes over the funding of the sector. The department will have less and less of a role in quality control, and there’s going to be services directed by capitalism...who’s going to evaluate and assess the quality of care in the sector?”
(5.1)

Similarly, support workers asked for clarification in relationships:

“Who will do what and how will it work with NDIS?” (SW 12);

“What will be the relationship between DHHS, us and NDIS?” (SW 4)

Consistent quality and a safeguard framework for the NDIS is still a work in progress. It is a fair reflection that there are issues arising from the NDIS pilot that lead participants to ask questions such as those above. A study was undertaken in 2013 to examine Tasmania’s readiness to provide this business of disability support in a changing disability marketplace (Flowers, 2013). The outcome of this assessment was that the assessors had “concerns” for some organisations that did not have the adequate governance, leadership, or management resources for a successful transition to NDIS (p 6). Their assessment didn’t examine readiness for the implementation of the Act, or the reduction of use of restrictive interventions in particular, but had a business focus. Nevertheless, this demonstrates a lack of readiness to tackle the issues imposed by the new system (Flowers, 2013).

Education and training

A total of thirty-three percent of organisations provide staff with training in issues associated with the use of restrictive interventions. This includes a total of thirty-one percent from large organisations who may have forty or more people being supported. Figure 4 (page 66) shows that the legal and ethical aspects of restraint use are two of the lowest types of training provided, with only eight out of seventeen organisation providing training in these areas. These results require address, given the most significant changes between the *Disability Services Acts* of 1992 and 2011 are the legal and ethical issues associated with the use of restraint.

Eighty percent of clinical respondents identified that they needed training in areas associated with the use of restrictive interventions, and procedures for organisations proposing the use of restrictive interventions. Twenty-seven percent of these indicated a strong need for training in these areas.

There are several organisations that provide training for support worker qualifications. This includes TasTafe as the major provider, as well as other registered training organisations. Throughout TasTafe’s Certificate III in Disability, the course coordinator invites industry representatives to provide contemporary insights into the sector and current issues. For example, in 2014, this included a

day of positive behaviour support training and an information session regarding the use of restrictive interventions. Other ad hoc discussion about this issue may occur throughout the duration of the course.

Clinician graduates may or may not have had training in disability and positive behaviour support. Typically, this would need to be learned in the position, with additional training being provided by the employer, DHHS. From a total of approximately thirty-eight clinical staff, only one third have had formal training in positive behaviour support. These figures are low, considering this is a core function for these team members. Once this was identified, through the course of this study, I embarked upon a formal education and training session for all clinicians. This was particularly well attended (approximately seventy percent of clinicians attended) and clearly demonstrated a need. Throughout the course of these sessions, some interesting attitudes were revealed. For example, some clinicians appeared to disagree with the concept of a functional analysis. The reasons cited were that not all people are capable of learning; therefore the concept of replacement or functionally equivalent behaviours was problematic for them.

Incidentally, these clinical teams currently play a major role in supporting organisations. Traditionally, it has been difficult to fill certain allied health professional positions and retain these positions in Tasmania. One of the reasons for this is some of the professional groups which are employed in the disability sector cannot train in Tasmania. The University of Tasmania does not provide a training program for occupational therapists, speech and language pathologists, or physiotherapists, who traditionally play an integral role in disability support.

The issue of support worker skill, as well as management skill and readiness for the new disability system is being examined closely by the Tasmanian disability services sector. With the aim of establishing the disability industry as an industry of choice, and in preparation for the challenges which the introduction of the NDIA may lead to, NDS Tasmania and Skills Tasmania have partnered to sponsor the development of an industry workforce and skills plan, which spans the years 2013-2016 (NDS, 2013). The following have so far been identified as skill development priorities:

- Functional literacy and numeracy
- Management and leadership
- Change management /adaptive management and leadership
- Business management skills
- Support work (including behaviour management) *“skills and knowledge in working sensitively and effectively with a wide range of behaviours is a continuing skills gap within the workforce. Demand for high level skills, knowledge and experience of behaviour management will grow as the NDIA roll out and support work takes place more and more in community or home settings” (p16)*

- Collaboration
- Social care professionals

In terms of skilling the workforce for the future, the intended outcome of this collaboration is as follows: *“a workforce that is committed to continued skills development that has the competency and capability to support new ways of working with consumers and their families and carers; and a responsive VET system that offers best quality training and support for the current emerging workforce”* (p20).

The department has no coordinated training strategy that provides different levels of training in a coordinated approach for all who work in the sector- including clinicians (Foss, 2011). The department does provide training money for the community sector organisations to up skill staff; however, it does not necessarily emphasise what training this needs to be, nor provide a coherent strategy for implementation of structures to allow for the regulation of restrictive interventions.

The training provided to clinicians in the department in the past has been dependent on individual interests and requests. Each allied health professional within disability and community services is afforded one thousand dollars per two years to spend on training and education. In my professional capacity, I am aware currently training is not provided in a coordinated manner for staff regarding positive behaviour support, writing support plans, and associated issues. Commencing in 2006, a series of training sessions were provided to the clinicians and broader sector from the Institute of Applied Behaviour Analysis (IABA). This provided staff with the means to assess and develop support from those with behaviours of concern. This was reported by the clinicians participating in the focus groups as an advantage. For the first time, they had a framework and a theoretical basis by which to address the issue of behaviours of concern.

Focus groups overwhelmingly identified training as an issue:

“...probably the most complex people in the world and they’ve got the least skilled people looking after them.” (2.2)

As identified in the literature review, lack of education and training of support staff has been identified as one of the barriers to the minimisation of restraint in human services (Rimland, 2011).

Support worker skill

In Australia, sixty-two percent (three thousand one hundred) full time equivalent personal care, community care disability, and residential support workers are qualified to VET sector level (NDS, 2013). Education, training, and the skill level of staff has been an ongoing issue in disability services, given there are no minimum qualification requirements in the award for support workers. One of the barriers identified to the use of alternatives to restrictive interventions is lack of adequate

education for staff (APS, 2011). Not surprisingly, increased skill in managing behaviours of concern has been shown to reduce the level of restrictive intervention use (Maguire, Young, & Martin, 2011). Formal qualifications in disability studies are only identified as ‘desirable’ in some position descriptions; some organisations have stated their preference to hire on the basis of attitudes and values.

Respondents considered that greater education and training was required in order to successfully implement the requirements of the Act. The majority of participants considered that support worker staff currently do not possess the necessary skills in order to successfully implement the Act. That is, the skills to seek alternatives to the use of restraint, to understand what restraint is, and to write and implement BSPs. Support workers identified their lack of skill as being a major barrier:

“...skill level of staff is a real issue.” (SW 6)

Staff also believed that the changes to the sector and associated training/education had led to changes in the type of skill support staff possess. Many participants commented that in order to implement positive behaviours support, as per the spirit of the Act, they required specific training in skill development for people with disability. Support workers stated that since the introduction of the certificate III and similar qualifications, this training didn’t necessarily equip staff with the skills they require to manage increasingly complex situations.

Participants strongly identified a decrease in skill level in more recent years. Several reasons were cited for this, including the change in training provided by institutions, and a lack of training provided by clinical teams within the state government. Discussion around the specific skills of a social trainer led to a discussion about the skills these workers had in aspects of positive behaviour support-for example, task analysis, prompting and fading, and so on. Social trainers were specifically trained at vocational education and training level to assist the skill development of those living with disability. Social trainers were taught how to complete a task analysis, provide prompting, reinforcement, and so on in order to teach a specific skill. It was thought that such skills would allow support workers to participate in skill development with the people they are supporting. Given that a large focus of behaviour support plans is the skill development of a person, this aspect of support worker skill is particularly relevant. Support workers, themselves, expressed the loss of the social training positions:

“The loss of social trainer positions has left a skills deficit.” (SW 3)

Other stakeholder groups recognised that the sector expects people to perform relatively complex support tasks, often with little training. One clinical focus group identified that the skills deficit was so great that some staff had lost sight of what was reasonable. They gave the following as an example:

“...I had a couple of staff approach me and highlight to me that the client goes to bed at seven on clock at night and doesn’t wear pads and is left there until seven in the morning. Lying there in her own filth.” (2.1)

Similar to other issues raised in these forums, the focus group participants were not necessarily holding the support workers responsible for the skill deficit, but rather the sector more broadly:

“...we put people into the field, work in isolation, poorly trained, by themselves. (5.2)

The manager of one organisation, in no uncertain terms, reported that her staff did not understand the issues associated with the reduction of restrictive interventions within that organisation. This organisation did not respond to the compliance letter after repeated mailings. However, they eventually telephoned, after repeated requests. When questioned about whether the manager believed that the staff of the organisation understood the issues associated with the reduction of restraint, the Manager reported “No, not at all, most of the staff here are really stupid, however for the purposes of this I will say they do.” The reliability of the information provided therefore needs to be considered. This also raises the question, if she thinks this of her staff, why are they not participating in training to overcome these skills deficits. Or indeed, why were they recruited to undertake their roles.

Comparison to other jurisdictions

This perception from clinical staff was mirrored in the support workers discussions. Participants perceive a difference in the training provided in the area of aged care, compared to disability. Participants believed that the aged care sector was ahead in their training provision, due to the profession being viewed as more attractive. Participants believed that recent recognition of qualifications, and increased availability of further training in aspects of aged care, had greatly assisted with this. Participants also believed that the same needed to happen with the disability profession. In contrast to the disability sector, the aged care sector in Australia provides a number of initiatives to encourage direct care workers to undertake further education and training to enhance

their career and level of skill (Department of Health and Ageing, 2012). There are clear pathways of educational advancement: for example, from personal care attendants through to enrolled and registered nurses. Eighty eight percent of the direct care workforce had post-secondary qualifications in 2012, an increase of eight percent since 2007. As one clinician identified:

“clearly, training for workers is important...I think it might be an idea to need to have qualified workers with some sort of qualification, but maybe for asking that maybe they do need to be paid more. Maybe then we’ll be able to attract better quality support workers and support workers that will be around for a little while longer...” (5.3)

Training for Guardians

In Tasmania, as in other Australian jurisdictions, a formally appointed guardian has a role in approving and monitoring the use of restrictive interventions. Public Guardians are employed by the Justice Department to make decisions in the best interest of a person who does not have the capacity to make such decisions. Private Guardians may be appointed by the Guardianship and Administration Board, and may be a family member, or someone close to the person living with a disability. A Public Guardian would be selected according to relevant selection criteria, however would not need to be well versed in contemporary aspects of specialist disability services; the only essential requirement is a current driver’s licence. These are classified as clerical positions, rather than allied health. A Private Guardian may not necessarily have any particular skills in managing disability or behaviours of concern.

Clinical focus group participants raised the issue of their level of training around this specialised area. As one focus group member stated:

“The level of training of Public Guardians around those kind of decisions is, I think, something I’d probably question, and the level of support for them as well. What if they make the wrong decision and I don’t know what the wrong decision is, but how supportive are they around making these absolutely, completely life altering decisions.” (5.2)

This issue was also raised at a National forum for discussion with NDIA, regarding how restrictive interventions could be regulated when the full scheme is in place. NDIA discussed the regulation being conducted in each state by Guardianship and Administration boards. The issue of guardians and their training was raised as a constraining factor against this idea for regulation. This remains one of the potential national regulation options in the NDIS roll out.

Skill in managing behaviours of concern

Tasmania has the lowest rate of adult literacy in Australia. In 2006, forty nine percent of adult Tasmanians did not have the basic literacy skills to enable them to cope with the demands of everyday life (Tasmanian Government literacy action plan) (The Department of Education Tasmania, 2010).

Clinical focus group participants strongly identified that, in addition to general support worker skill, literacy rates were also relatively poor in this population. This was identified as impacting on their ability to understand BSPs and to make adequate data recording and incident reports, all of which helps with understanding a behaviour and trialling alternatives. Behaviour support plans are, at times, lengthy and detailed documents, utilising a specific language and terms. Poor literacy was discussed amongst many clinical focus groups.

“I know this sounds really awful, but we’ve got a lot of support workers out there who can’t read and write exceptionally well...” (1.6)

“It’d be fantastic if there was like a really big push for some education with even staff and clients at the same time. It could be really beneficial because sometimes – I know sometimes with support workers they can struggle with literacy as well.”(4.1)

Through their planning process, National Disability Services (NDS) identified that functional literacy and numeracy within the workforce is a concern. They identified that indicators for functional literacy and numeracy in Tasmania are the lowest in Australia. They further identified that the demand for good literacy and numeracy skills will increase, as workers will be required to be more autonomous and responsible for planning and reporting in the future service system (NDS, p15).

Clinical participants thought that the use of restrictive interventions may not be deliberate, but may arise out of lack of understanding or the ability to generate alternative strategies. Some of this might be about the aforementioned attitude. That is, staff seeing a need to protect a client, seeing them as not able to make decisions or take a risk. If staff are unable to see alternatives and innovative solutions to an issue, they may be more likely to use a restrictive intervention as a strategy. This was discussed in clinical focus groups, and one participant commented:

“I think a lot of things are done as restrictive or aversive, but that isn’t the intent. It’s done innocently with not recognising that it is aversive or restrictive things like locking food cupboards and banning people from kitchens. That sort of thing isn’t often seeing as being

aversive or restrictive, so people do that because it makes good sense in the setting that they're in, without thinking should I be doing this? Or is there a different way?" (1.2)

Support worker participants agreed:

"...sometimes we don't realise it's a restrictive intervention." (SW 8)

Clinicians themselves also identified that they are unsure when something may be restrictive and when something is therapeutic.

"The capacity to recognise an intervention to be therapeutic or restrictive-how is this determined?" (F)

"How do we identify less obvious restrictive practices and alternatives to their use?" (O)

In addition to the ability to read and understand support plans is the necessity for direct support workers to understand the communicative intent of behaviours of concern. That is, a person with a disability may lack the necessary skill in a particular environment to communicate in an appropriate manner-this communication may therefore be exhibited in the form of a behaviour which is of concern. For example, a person unable to say they need a break from noise and stimulation may instead start to hit and bang things until he is removed from the situation; this then becomes a learnt response. It is evident that some direct support workers do not understand this basic premise, which may very well affect the way the behaviour is managed. For example, during a recent education and information session in a community service organisation involving direct support workers, one support worker expressed his displeasure at being required to manage a person who regularly smears his own faeces. The worker believed that it was necessary for this person to be subjected to mechanical restraint to prevent the behaviour from occurring. They had not considered the impact of preventing this behaviour from occurring from the perspective of the person exhibiting the behaviour. Instead, they stated "I find it offensive" and similar sentiments. When it was explained that this behaviour undoubtedly serves a function for the person, this was a new concept for the worker. They had not considered the communicative intent of the behaviour, and therefore had not considered the impact of just preventing this behaviour. Positive behaviour support relies upon: staff seeking alternatives to the use of restraint; training and skill development; as well as the development and implementation of BSPs. Obviously, this relies upon understanding the positive behaviour support philosophy, as well as possessing the skills in carrying out the tasks required to modify behaviour.

Focus groups identified support workers' inability to generate alternatives to the use of restraint due to their inability to be innovative and to problem solve positive responses to situations. One clinical focus group participant identified:

“They don’t think laterally. They think, oh right well no, I’ll do that from now on, so that or I’ll lock that away so that it can’t be done. So they don’t do any on ground problem solving about situations, they tend to jump first to inhibiting I guess, inhibiting people doing something before problem solving it through...restrictive practice as such comes into play when people aren’t willing to problem solve.” (2.3)

Similarly, another clinician stated:

‘In day support, we’ll start to see lots of restrictive practices. Not in the sense that they’re forcing people to do something against their will, but there’s a lack of innovation and creativity in day activity.’ (5.1)

This is very much related to the discussion regarding lack of availability of training and education. Focus groups believed that workshopping scenarios and discussion of appropriate alternatives needed to occur to help teach those on the ground about what was restrictive and what are alternatives:

“They cannot grapple with it; they need a lot of workshopping about it and a lot of role playing, a lot of scenarios.” (2.3)

For more complex behaviours of concern, clinical members of the focus groups discussed the need for good quality Behaviour Support Plans (BSPs). Support worker participants reflected the need for clinicians to assist them write and implement programs of positive behaviour support. They appeared unsure who might assist them to do this in a timely manner, stating:

“Programs to develop the skill of a person require resources such as time to put into place. Who will do this?” (SW 4)

Participants reflected a wait list for the clinical team, as they, too, may be under resourced. There was a perception that this would impact on their capacity to provide alternatives in a timely manner, and therefore lead to the continued use of restrictive interventions. As one support worker stated:

“The amount of work DAAT has to do might affect the timeliness of the BSP implementation etc.” (SW 1)

Other groups discussed the idea that even with a well-developed plan, greater guidance and training is required for staff around the basics of positive behaviour support. Participants did not believe that there was enough basic knowledge about issues that might be addressed in a plan for the workers to be able to carry out the plan-or understand the need to fulfil the plans. For example, throughout discussion, one clinician stated:

“...so using the strategy strategic capitulation is very confusing for a lot of support workers, because they think, oh, you’re just giving in to them.” (1.1)

And another gave this example:

“...not fulfilling behaviour support plans - staff just ignoring them.” (5.1)

Whilst the exact issue differed slightly between stakeholder groups, there was a consistent message: that is, behaviour support plans are not implemented in a timely, efficient, and effective manner.

Who provides training?

Participants were unsure about who would provide the required training, given it has not been available to date.

“Where can we go for skill development?” (SW 11)

“Where is training available?” (SW 1)

Clinical focus groups identified they no longer provide such training, and they have noted the impact of this:

“...I do see the lack of generic training from us pulling the skill level down. The skills of support workers and managers have really plummeted I think since we haven’t been doing the generic trainings that we did.” (2.3)

As raised in the Senior Practitioner/Disability Assessment and Advisory Team (DAAT) reference group, established to provide greater assistance to the sector than one person could provide, it is evident each DAAT regional team operates differently in their provision of training to the sector. Some teams provide person specific training, others provide more generic education and training about positive behaviour support, understanding behaviours of concern and so on. Of interest is an issue emerging from the introduction of NDIS. The DAAT currently provide in kind support to participants of NDIA. There remains uncertainty in the teams about their role and function, even existence, when the full scheme is implemented. Of significance is the belief the teams will no longer be employed in their current form by the State Government. Indeed, some other states, such as NSW, have already taken steps towards removing similar teams from government business. Currently, some providers and some CSOs conduct the types of activities which the DAAT offer. Thus, some DAAT members see themselves as being in competition with others in the sector. This leads to reluctance, on the part of some DAAT members, to conduct training for the sector, and in effect up-skill the competition. Throughout the course of my professional practice, such reluctance has been expressed on many occasions. If DAAT are no longer providing this training, this significantly reduces the free of charge training opportunities available to the sector. This may have a significant effect on the capacity of the sector to respond to issues associated with behaviours of concern and alternatives to the use of restrictive interventions. In other states, for example Victoria, Office of Professional Practice provides training to the sector. Tasmania has a reduced capacity for this; given the OSP is essentially one person.

One interview participant also identified parents may require support to look for addition training in the management of behaviours, and stated:

“...but I think some families really would be grateful because they don’t feel that comfortable about what they’re doing and would be quite grateful to see that there was another option.”
(SW 4)

Understanding the Act

There was some discrepancy amongst participants about whether the Act is easily understood by people from all levels of service delivery, and therefore additional training to help understand this was seen by some as necessary.

“I think what I really like is, it’s written in plain English.” (4.1)

“This one’s going to sound silly, but as a student I think when I was introduced to the Act for the first time, I didn’t really know the concept. I mean I know it related to legislation, but it’s

probably the problem of the support workers who don't know the spirit of the Act, what's an act, what is the Act going to tell me" (1.2)

Table 8 shows clinicians identified a need for clarification around the legislation, and training in particular aspects of the legislation. Descriptive comments support this:

"Training around where legislation is unclear." (K); "Examples of environmental and personal restrictions would be useful." (D)

Some clinicians clearly confuse the two definitions contained within the Act-for example, identified a personal restriction in terms of:

"Unnecessary limited access to clients' caffeinated drinks." (A)

"Having possessions taken away." (B)

These would be more accurately defined as environmental restrictive interventions.

Some inaccurately gave examples of environmental restrictions as:

"Client being left in wheelchair or bed for extended period of time in the day when they are unable to get out independently" (C);

"Secure gate" (F);

"Locking gate to stop a client running on the road." (E).

These would be defined as personal restrictive interventions.

This is another example which supports the idea of further training being required.

Throughout the course of my professional practice, both departmental staff and organisational support workers often reported that it is the CEOs and managers of organisation who need to understand the Act and interpret this for their workers. Direct support workers have very little time to research such issues, and need to react quickly in certain situations. This again highlights the importance of the role of leaders and managers in understanding such legislative requirements, and the spirit and the intention of the Act.

Recruitment practices

Recruitment practices for support workers was also discussed as an issue contributing to low skilled workers. The field of disability support needs workers due to high rates of turnover, therefore unskilled people are able to gain positions, without necessarily wanting to pursue a career in the field.

One clinical focus group discussed the notion people were often recruited to work with people living with disability due to vacancies being available in this area, rather than people being suited to the work. One clinician said the following when discussing her thoughts, Centrelink perhaps force people with the wrong attitude into this type of work, which is one of the reasons skills are poor- because skill, values and attitudes are not necessarily the basis for recruitment:

“...if it’s not for you and yet you’re being pushed in some direction by yet another institution [Centrelink] if you like, because in Tasmania our options for employment are quite low, and for younger people it’s even lower. Yeah, maybe we do have people in the sector who maybe previously would be pushed into it, but now we have people who are.” (5.1)

Participants from many support worker focus groups discussed the need for increased education levels for staff who are employed as support workers. Staff believed that there should be a minimum requirement of Certificate III in Disability training for entry into the workforce. One large organisation identified their recruitment practices focused on the attitudes and values of their staff rather than formal qualification/skill. It was their perception the latter can be taught more easily than the former.

Consistency of support

Due to the philosophy in the sector that dissuades one organisation providing whole of life service for an individual, people are often supported by more than one organisation. Participants in the support worker focus group identified the need for consistency across organisations, and expressed concern that organisations may view things differently. During the support worker focus groups, a participant stated:

“We may get disagreement amongst services.” (SW 9)

Discussion in another focus group identified that there is variability across services:

“Different providers have different standards.” (SW 3)

This issue was also discussed in clinical focus groups. One member gave an example of a client who moves between five different services in one week.

“One of the things that we talk about all the time is consistency for the client. The services need to recognise this as well” (1.3) and;

“...part of the problem is everyone is changing all the time.” (2.4)

Focus group participants identified that consistency in frameworks and opinions regarding restrictive interventions are also important.

Support workers identified this variability does not only occur between services. Consistency was also highlighted as necessary between staff of the same organisation, families, and others involved in supporting the person living with disability. The member of one support worker focus group highlighted the need for internal consistency with regard to restrictive interventions.

“We need everyone to be on the same page.” (SW 4)

A similar discussion occurred in another focus group:

“Everyone needs to be of the same mindset-this can be hard to get staff and family to agree” (SW 8)

and also in the clinical focus groups:

“We all need to be on the same page, the parent and the people being supported.” (4.1)

Both the support worker and clinical focus groups identified that families may have different expectations and identified families are not bound by the act in the same way organisations are. Workers identified this will have implications for the support and for relationships with families.

“What if the family expect us to use restrictive interventions-then we will be back to square 1?” (SW 7)

Participants discussed the need for families to be in agreement with the proposed changes, and expressed that at times it can be difficult to access families for consultation. One focus group member stated:

“We need family involvement for consultation.” (SW 6)

This was also identified in the advocate interview

“...obviously people who are still living at home and that’s what I wonder about because we have the same issue with our service-how so we reach those people. Some are fantastic but some definitely still have that paternalistic view.” (4.1)

It is often the direct worker/support worker who will be exposed to the greatest range of input and opinion. They may be the communication point for their organisation’s management, the family of the person being supported, the clinician, other workers, and so on.

Focus group participants appeared to be strong advocates for the need to understand the people they are supporting, as well as their views. Many comments such as this were reflected:

“Where is the client in all of this? What about their views?” (SW 11)

This included discussion about whether clients would understand what the new processes and alternatives are, and whether or not they understood they could object to the use of restrictive interventions. As one support worker focus group participant stated:

“What are client’s expectations? Do they know their rights?” (SW 3)

Attitudes

“...I think we’ve got to undo a lot of attitudes before you can start doing that [provide advice]. I think people think they’ve put them into group homes everything will be rosy but they took the same attitudes into the group homes. What they need to do is take that institutional attitude out of the house. Doesn’t need to be and shouldn’t be set up according to the staff’s needs. It would be set up according to the client’s needs.” (2.2)

This quote highlights a common discussion amongst many focus groups, that is, successful support not only relies upon differing accommodation models, but also relies upon changes in the philosophy of support and support workers attitudes. It was commonly discussed that this would be necessary in order to successfully implement alternatives to the use of restraint. As participants in the several support worker focus groups stated:

“Old attitudes and ideas need to change.” (SW2)

“Individual staff values need to change.” (SW 10)

Support worker and clinical focus group members discussed their beliefs that the sector’s attitudes are slowly changing towards positive behaviour support, but still need to continue to evolve in this direction. As focus group members stated:

“Staff attitudes need to change, although these are changing slowly.” (SW 3)

“I’ve been doing this five and a bit years. I’ve noticed quite a big difference-for the better-which is great.” (4.1)

Whilst the interview with the family member focused on practices in the education sector, they did highlight the difficulties with inconsistencies occurs across sectors. One practice might be acceptable in an education setting, but not in an accommodation setting. This makes things difficult for people who access multiple settings.

Support workers attributed this change to several factors, including younger people moving into the profession and moving away from a model of nursing home ‘care’. Support workers believed that younger people have a more human rights based perspective than older generations. One support worker also believed that people moving from interstate was another reason for this shift:

“There is a change in attitude- a move away from paternalistic attitude- helped by people coming to work from the mainland.” (SW 3)

Other reasons cited included outsourcing to the community sector, leading to a change in attitudes- including community attitudes.

The literature shows staff attitude is a factor which is considered to be relevant to the type of support a person receives. The literature identifies some staff may seek to take control over the lives of those who are supported (Paterson et al., 2011). This was a strong theme highlighted in clinical focus groups, with comments such as the following being made:

“...meanwhile, the client is still basically going through these horrendous days and nights where the staff are bullying her.” (1.1)

“Isn’t it interesting when you go to places where the behaviours [of concern] are-is where the staff are control freaks.” (2.2)

“...those staff are almost modelling bullying behaviour...” (3.2)

One focus group discussed a perception of pity for those with disabilities being evident in the sector. Whilst not necessarily an attitude of control, this further exemplifies the lack of equality of relationships. One member of this focus group stated:

“It’s really interesting that you do have support workers who think, who almost have pity for the client...poor darlings...we’ll just keep them happy. They’re not doing it to belittle the client that’s where they’re at.” (1.3)

Participants in the clinical focus groups highlighted a perception that exists in the disability sector, that behaviours of concern are exhibited by people with disabilities in order to be malicious or manipulative towards those who support them. It is feasible that this may then lead to the need to an imbalance in the support relationship. As participants of one clinical focus group stated;

“They see the clients as manipulative...it becomes them and us” (2.2)

“...or as manipulative or something, other than just the client doesn’t have the capacity...”
(2.3)

Rather than one who includes the client in their support in a more equitable manner:

“...probably the biggest one will be that sort of culture shift and mind shift for people actually getting active support...” (4.1)

That is, a support arrangement whereby the person is supported to actively participate in all areas of their life and environments.

There is some suggestion from the stakeholder groups that a negative attitude reflects the underlying value placed upon people with disabilities. That is, no-one will really notice if things are bad for them, no catastrophe will result for the larger community due to the low visibility of people with disabilities in our community. Focus groups raised the underlying theme that if people with disability were perceived as having greater value in society, those working with them would have

greater education, training and therefore skill. This statement made by clinical focus group participant shows the perceived lack of power held by people living with disability:

“...because the power station isn’t going to fall over. The screams aren’t going to be heard”
(5.2)

Chapter 4 in brief

Chapter 4 has described the data reported through data collection activities. This data provides evidence that restrictive interventions are still used in the Tasmanian disability sector, due to several barriers to the implementation of Part 6 the Act. These barriers include: the need for greater input from leaders and managers; a stronger system of governance; the need for greater access to training and education; a need for consistency of support; and negative attitudes towards those with disability within the sector.

Chapter 5 goes on to elaborate on the main reasons the Act has not been fully implemented in the Tasmanian service system. That is, why, in spite of a legislative framework, practice is not consistent with the requirements of this legislation.

Chapter 5
Critical Evaluation

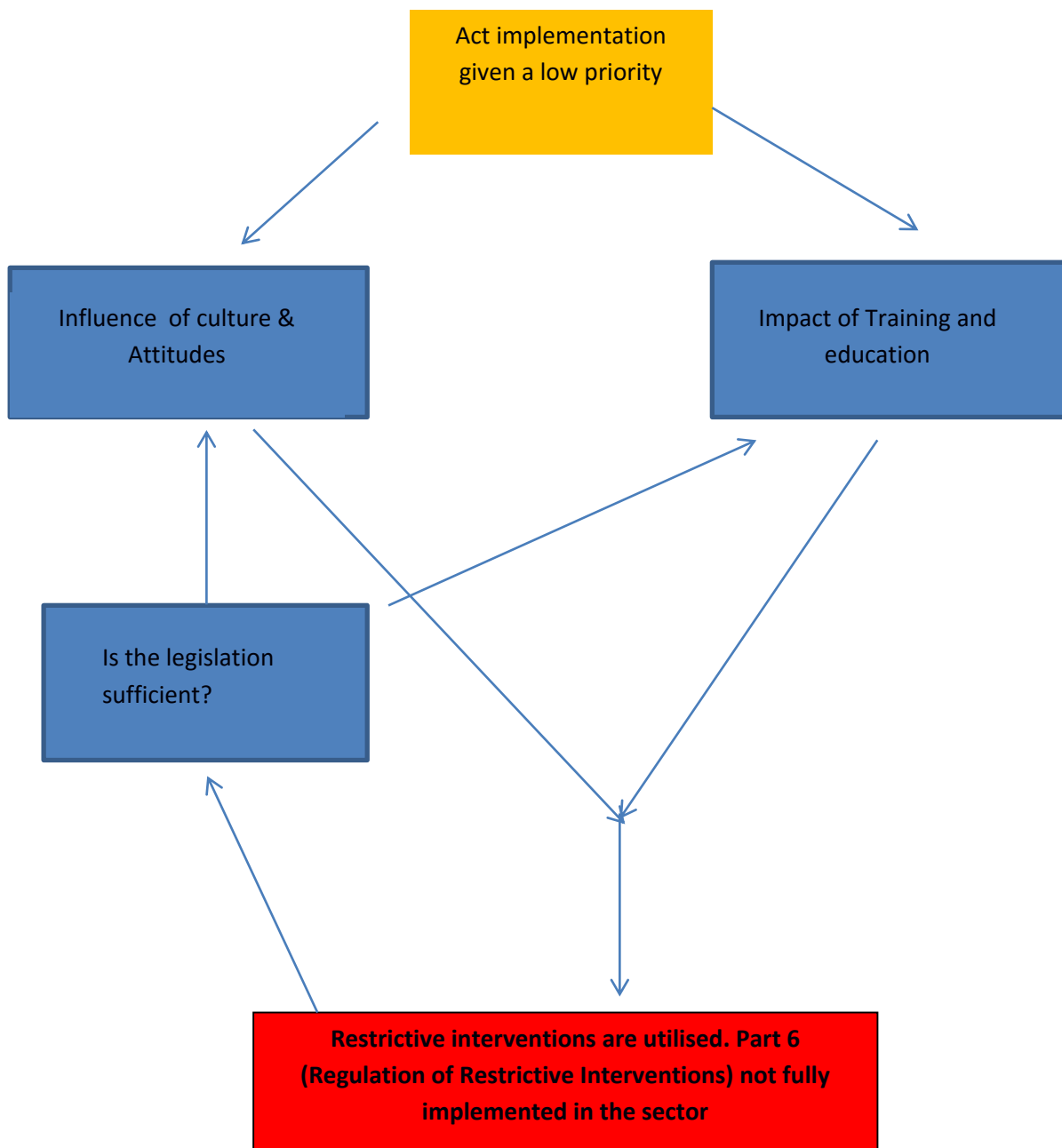


Figure 7: Mud-map of critical evaluation of study results

Chapter 5

Critical Evaluation

Introduction

“...the moral legitimacy of the work is undermined by the gap which separates the rhetoric of policy from the sharp reality of practice” Wardhaugh & Wilding (1993, p.16).

The previous chapter highlighted the main themes emerging from the data collected in the current study. These themes emphasise the barriers to the implementation of Part 6 the Act. The literature reveals the implementation of legislation, and policy designed to reduce restrictive interventions, has been difficult in some other jurisdictions as well, and a difference between practice and policy can be evident-as reflected in the above quote. This results in the continued use of restrictive interventions. An examination of this in Tasmania has found some similarities to this research, and some clear barriers to the implementation of such legislation and policy.

Figure 7 shows a summary of what will be discussed in this chapter. I will argue that the barriers to implementation identified through this study are sufficiently evident that it cannot be argued the Act has been fully implemented. Whilst it is acknowledged the Act was only proclaimed on 1st January 2012, I will consider whether the minimal implementation of Part 6 of the Act is due to a diminished priority being given to this task. The results demonstrate that input from leaders and managers is not sufficient, neither is the system of governance. If priority was given to this implementation task, these groups would be very involved. Other factors contributing to lack of implementation will be considered. The results of this study show that the culture and attitudes existing in the sector are inconsistent with practices which aim to reduce the use of restrictive interventions the impact of this upon the reduction in the use of restrictive interventions will be discussed. This chapter will also demonstrate how the study results show skill deficits in the sector staff and the impact this may have on the implantation of regulation of restrictive interventions. This skill deficit has a detrimental effect on their ability to carry out alternatives to the use of restrictive interventions.

This chapter will also argue that, as shown in the study results, there are specific issues associated with the legislation which render it difficult to fully implement. Also posed for consideration is the possibility legislation alone is not sufficient to bring about the changes required for legislation compliance.

Indeed, there are small pockets within disability service organisations who have implemented the legislation and associated policy well. These organisations comply with the legislative requirements and have reduced the use of restrictive interventions within their organisation. This chapter will also identify the necessary conditions to achieve compliance.

The impact of legislation on practice change.

The current study in the context of experience from my professional practice, found that restrictive interventions are still used within the Tasmanian disability service system, in spite of legislation designed to minimise or obviate the use of such interventions. The continued use of restrictive interventions in the face of legislation designed to minimise their use is clearly not only an issue for Tasmania. In a comparison of Irish and Victorian policies aimed at the reduction of restraint, Rickard, Chan, and Merriman (2013) identified issues existed in the implementation of new policies aimed at the reduction of restraint. Whilst Victorian legislation has brought about some decreases in some types of restraint, there are increases in the numbers of people routinely subject to chemical restraint and the state has seen an increase in the numbers of people with autism who are subjected to restrictive interventions (Webber, Chan, & French, 2014).

Gaskin, McVilly, and McGillivray (2013) highlight the mismatch between policy and practice, and state that, in spite of expectations to the contrary, restrictive interventions are used in services which support people with developmental disabilities. Similarly in psychiatric care, legislation, policy, and discussion emphasises coercive interventions should not be used in psychiatric care; however this is not reflected in practice (Keski-Valkama, Sailas, Eronen, Koivisto, Lonnqvist, Kaltiala-Heino, 2007). Paterson, Wilkinson, Leadbetter, Bradley, Bowie, and Martin (2011) report that the misuse of such coercive techniques is reported across much of the world. As suggested by Chan, Webber, and French (2014), it may be too early to determine whether legislative developments in Australia generally have been successful in preventing, reducing, and eliminating the use of restrictive interventions, however it is useful to attempt to determine the barriers specific to Tasmania, and whether these are similar to other jurisdictions.

A literature search conducted by Romjin and Frederiks (2012) revealed that policy is not always in line with practice. The extent to which restrictive interventions are utilised in Tasmania is difficult to determine; however, this study provides evidence to suggest that in Tasmania, over two years after the implementation of the Act, key groups within the sector generally do not fully comply with the requirements of the Act, and feel ill-equipped to do so. Some members of the sector are still quite oblivious to their obligations under the Act.

Throughout the course of professional practice over the past two to three years, I have held information and education sessions. These sessions were attended by Tasmanian service system

workers, and outlined changes to the Act, and workers' obligations under the Act. During sessions held late in 2014, workers were still indicating they knew something was different about the legislation, but they still weren't sure of the details. Similar responses were received when these sessions were first conducted, when the Act was first proclaimed. The disability workforce can be quite transient, and therefore it may be difficult to capture all of the workers all of the time in such training sessions. This highlights the importance of organisations ensuring policy is implemented, accessible, and understood by new and existing workers.

The spirit of the Act emphasises a greater human rights focus in the support of people living with disability. The translation of this, in terms of supporting a person with a disability, should mean that person has greater opportunities for participation, greater choice, and greater freedom to access all aspects of their environment-that is, less restriction.

Certain groups within the sector have certain roles in the facilitation of this greater freedom and the minimisation of the use of restrictive interventions for people being supported. For example, (a) clinicians have a role in the identification of restrictive practices, recommendations for alternatives, identification of therapeutic practices, and assistance as an "expert" for the purpose of applications for the use of restrictive interventions; (b) support workers also have a role in the identification of the use of restrictive interventions and the use of alternatives; (c) CEOs and managers of organisations have a responsibility to ensure compliance is met within their organisation through training, policy, governance and so on. Board members also have a role in ensuring organisational compliance with funding agreements, and would presumably be interested in their organisation's compliance with legislation.

The main mechanism outside organisations, provided to help individuals and organisations understand their role and implementation requirements under the act in Tasmania and Victoria is the newly formed position of Senior Practitioner. Essentially, the Tasmanian disability service system provides this person to monitor and regulate the use of restrictive interventions.

These activities have coincided with National Disability Insurance Agency (NDIA) funded activities which are aimed at preparing the sector for the implementation of National Disability Insurance Scheme (NDIS). These activities complemented those of the Senior Practitioner, and included person centred workshops and education sessions. The concept of person centred support is based on the core beliefs that:

- (a) All human life is of value
- (b) Everyone, whatever their disability, can exert choice
- (c) People who are disabled by society's reaction to their physical, sensory, or intellectual impairment and to emotional distress have the right to exert control over their lives; and

(d) People with a disability have the right to fully participate in society (Richmond PRA, 2013) Such person centred philosophies are consistent with positive behaviour support, and not the use of restrictive interventions.

Throughout my role as Senior Practitioner, I utilised various strategies by which to assist sector stakeholders to understand the Act and its requirements. This included: (i) information/education sessions regarding the content of the act, more targeted sessions regarding alternatives to the use of restrictive interventions, as well as resources assisting understanding definitions and other aspects of the Act; (ii) targeted audits of organisations to determine their use of restrictive interventions; (iii) provision of a contact point for specific service related questions; and (iv) assessment of quality of support plans as well as positive behaviour training. This study has revealed, in spite of these ongoing activities, there remains an ongoing lack of understanding of the Act generally, about specific roles, definitions, and so on. This highlights these activities alone are not sufficient to help organisational staff understand their role.

In its first year of operations, the Victorian OSP, a team of allied health professionals and researchers, focused on partnerships to bring about change in the systems, in order to effect change in individuals and achieve incremental success in the support systems (OSP, 2008). In order to bring about change for a person, it was considered necessary to bring about change in the systems around that person. A stakeholder survey in their first year of operation identified areas for development which were actioned in the next reporting period. This included: greater availability of information regarding changes to enable greater access for people. Requests for information, increasing training advice and consultancy were identified as issues people required greater access to. These strategies perhaps highlight an identified need for greater communication of information between the stakeholder and the OSP in Victoria in this formative period of time. Webber, Chan, and French (2014) highlight the successes in the reduction of use of restrictive interventions which were brought about subsequent to the introduction of the *Disability Services Act 2006* (Vic) are as a result of a “broad based structural response” (p 21). They outline that, in addition to the legislation, factors including the national and state level policy regarding the human rights of people with disability, government funding for the education of disability support workers, and the establishments of research have also contributed to this success. This may provide some guidance as to what is required in Tasmania, to assist increased implementation.

During the two year period since the implementation of the Tasmanian Act, the sector has been required to consider significant changes to its service system, both in terms of the new Act and the changes brought about by NDIA. This may underline some of the reasons why stakeholders are still unsure about relevant aspects of this Act. Other possible reasons are outlined below, and include: the lack of prioritisation of this as an issue; attitudes and cultures inconsistent with the Act

philosophies; inadequate training and skill in the sector staff; and issues inherent in the legislation itself.

Act (Part 6 regulation of restrictive interventions) is given a low priority.

The implementation of the Act coincided with the NDIS pilot and focus towards 2019 when NDIS will be fully implemented. In order for organisations to remain viable into the future, significant changes have been required. This has been a large focus for organisations over the past two years. The Act is not irrelevant in this new system; the changes include supporting a person in a manner which is consistent with the principles of the Act. However, perhaps it is the case business processes are taking precedence over the principles of care.

In 2012, The Council of Australian Governments (COAG) agreed to the higher level principle for NDIS that stated NDIS “...maximises the benefits of a market based approach to disability support services including consideration of a costing structure that fosters competition and choice...” (COAG, 2012, p3). Organisations may understandably be concerned about their capacity to respond to the new service system requirements, and their need to compete in this system. Previously, competition has not been an issue for Tasmania, given the size of the state and limited number of specialist disability services. Providers are being required to commence operation in a market based approach to disability support- which they have not previously. An initial report conducted by an external auditor, in order to determine Tasmania’s readiness for the introduction of NDIS, demonstrates a real concern about organisational capacity, particularly in relation to business and financial readiness, governance, leadership, and management resources (Flowers, 2013). Philosophy or models of support were not examined. Thus, amongst all the changes, a positive approach to supporting individuals may take a backseat in terms of priorities, amongst all the other changes required to keep an organisation financially viable. The actual model of support for individuals may take a lower priority than business processes, because without attention to business processes, organisations may not remain viable in the new service system.

A further report regarding sector readiness was prepared, following an assessment conducted by the state NDIA implementation team. From eighty seven funded services provided with the survey, thirty commenced the survey and only eight completed the survey in full (DHHS, 2015). This response rate was poor (22%), however, the study helped to identify some perceived areas of need for further development. One of these was the need for development in middle management, frontline staff, CEOs, and board of management (BoM) in several areas, including cultural change and development in person centred organisational practice. This identifies, for the first time, the need to address the culture of organisations within the Tasmanian disability sector. The culture of residential support organisations is generally under-investigated (Bigby, Knox, Beadle-Brown, Clement, &

Mansell, 2012). It is also hypothesised this low response rate is due to lack of significance placed upon the survey and or topic.

It is tempting to argue that organisations may be attempting to prioritise systems of care, and attempting to support people in accordance with the new legislation. Although, throughout the course of my professional practice, it became clear provisions of the Act based around use of restrictive interventions are not the only area in which issues of adherence exist. For example, not all organisations adhere to the need outlined in the legislation to have individualised plans for all funded persons. This plan is to be prepared by or on behalf of the person after consultation between the person (or nominated person) and the secretary. This aspect of the Act is not within the jurisdiction of the Senior Practitioner, and may indicate organisations require additional support in the implementation of this aspect of the Act as well. This may provide further evidence a person centred approach takes a backseat to business viability and other aspects of service provision.

The incentive to be compliant with the legislation currently relies upon organisational culture and the attitudes of those within the organisation. Currently, the State Government has no method by which to fine an organisation for breaches of the Act. In a service agreement loophole, if a service agreement needs to be ended due to demonstrated poor service provision, this is very difficult to do. This results in a predicament as to who will provide support for the remainder of clients of the organisation- in some cases this might be up to four hundred people. Under such circumstances it is extremely unlikely any service agreement will be terminated by the government.

The Tasmanian Act prior to 2011, *Disability Services Act 1992* (Tas) outlined the standard that: “programs and services are to be designed and administered so as to be as free as possible from aversive, restrictive and intrusive treatment practices” (Schedule 3, Standard 9). Therefore, the general spirit of the 2011 Act in terms of positive behaviour support and minimising use of restrictive interventions should not be a significant deviation to previous support philosophy. The rigour about approval and monitoring is new, but not the nuances of positive support. Undoubtedly, however, the regulation and monitoring of these practices was previously very minimal, due to a lack of regulation in the 1992 Act. There is also little data about the use of restrictive interventions prior to the implementation of the Act.

Whilst the spirit of the Act does not represent a major deviation in support methods, consistent with other states in Australia, the practice of Tasmanian legislation including guidelines and regulation for support is relatively new. As identified by Romjin and Frederiks (2012), the scrutiny of the use of restrictive interventions in Australian legislation is relatively new. It may therefore be understandable this may take some time for the sector to understand the importance. A few organisations, however, have embraced this, through the use of key staff and addressing the attitudes and skill of staff.

In Tasmania, the quality of disability support work has very much been measured through inputs and activities, with less emphasis on client outcomes (Community Sector Relations Unit, DHHS 2014). By way of design, it may be that organisations have been focused on different priorities, and a shift in these is required. Similarly, Porter and Kramer (2011) (as cited in Webber, Chan, & French, 2014) believe governments and service providers need to think in value terms and focus on results achieved rather than costs.

The next sections will highlight the issues that need to be addressed if the Act implementation is prioritised by the sector. If the reduction of use of restrictive interventions is seen as a priority for the sector, the culture and attitudes of the staff would be assessed and addressed, similarly so would the skill and training of staff.

The influence of culture and attitudes upon Act implementation relating to regulation of restrictive interventions.

The current study identified the way in which people living with disabilities are perceived is seen as a barrier to the implementation of the relevant part of the Act. This study reveals that some negative attitudes towards people living with disability remains in the disability sector, which prevents true person centeredness and positive behaviour support. For example, attitudes of pity were evident; perceptions that service users were bullies and manipulative were reported or witnessed; staff were also described as bullies. Both clinical staff and organisational support workers expressed opinions that negative attitudes require address, in order to appropriately support people in a less restrictive manner.

Decreased value being placed on people living with disability may be one reason priority is not given to the implementation of the Act, which would involve improving their independence and quality of life. It is evident that sector attitudes reflect there will be no great impact to society if people with disabilities are not treated in a manner which would be considered best practice. This perception reflects the wider community attitude that people with disability in our society have very little status or influence, and so no catastrophe will result from supporting them in a manner inconsistent with the legislation. As such, there is no great impetus for change, and no real need to prioritise Act implementation.

Very few, organisations have the capacity to reduce the use of restrictive interventions since the proclamation of the Act. In my professional experience, the obvious element in those organisations, which has enabled restrictive interventions to be reduced, has been a person appointed to oversee this process, or to take the clinical lead in this process. These people are also trained in positive behaviour support, and therefore have been trained with contemporary views regarding the aetiology of behaviour and the manner in which this needs to be viewed and supported.

Are these attitudes changing?

This current study found that whilst attitudes in the sector are changing, they need to continue to evolve in order to fully implement person centeredness and positive behaviour support. The implementation of positive behaviour support will likely reduce the uses of restrictive interventions. In terms of the reduction of use of restrictive interventions, all organisations could benefit from their leadership promoting such implementation; this is what characterises the successful organisations.

Tasmania's disability service system has, in the past, relied on the development of services from a charitable and family basis. Whilst well-meaning, these services have perhaps continued without addressing redundant attitudes, and negative cultures continue to exist. A perception of workers needing to control service users was highlighted in this study, along with bullying and patronising, and paternalistic views towards people living with disability rather than a more person centred approach.

Consistent with findings in other studies, it was found that younger support workers were more likely to be viewed as having a culture consistent with inclusion and acceptance. Similarly, Yazbeck, McVilly, and Parmenter (2004) found that younger people generally reported more positive attitudes toward people with disability than older people. As identified by Mackelprang and Salsgiver (2009), a new culture is gaining recognition gradually. The suggestion in the Tasmanian context is that these attitudes are changing due to the influence of younger people with alternative views, rather than through any formal or intentional mechanism to address attitudes. More recently, however, attempts have commenced to modify these attitudes in preparation for NDIA with an emphasis on person centred planning.

The DHHS (2015) have identified that changes are required in order to transition to an NDIA approach to service delivery, and these changes include the need for service providers, people with disabilities, their families, and carers to be given the opportunity to develop skills in the areas of knowledge and attitudes, to move towards a new way of thinking. These opportunities are being provided prior to the changes that are required, in preparation for these changes. This reports notes that whilst the sector is a long way from being ready for the implementation of NDIA, some paradigm shift has been noted from those who were operating within a "charity based or developmental model" of service provision (DHHS 2015, p9). These changes are not elaborated upon.

Culture is presumably considered important by NDIA. They are currently undertaking a cultural mapping project within their own agency, in order to determine the extent to which they are truly person centred. This project involves the assessment of values such as assurance, empowerment, responsibility, learning, and integrity (NDIA, 2015)

The evolution from the institutional medical model of care for those with disabilities has occurred only relatively recently. It may be understandable that attitudes are still lagging in this model, as opposed to the psycho-social educational model of support. Those who work to support those living with disability in order to regain some control, due to their own issues of lack of self-worth and so on, may enjoy the perception of carer as ‘martyr’ or ‘saint’ (Harrison, 2000) and therefore struggle with alternative philosophies, and models of care based on equality.

As highlighted earlier, the rate of reduction of use of restraint in the Tasmanian health system is lagging behind other states. The Tasmanian Disability Services legislation reflection of this human rights approach came approximately six years after similar Victorian legislation.

Deinstitutionalisation in Tasmania commenced some years after other states. Beadmeade (1997) noted that, at the time of writing, all Australian states, with the exception of Tasmania, had enacted anti-discrimination laws to protect people in the areas of education, employment, and services. The Tasmanian health system has been assessed as requiring significant address, particularly with regard to culture. A recent investigation into the Tasmanian Health system reveals a “...deeply engrained culture of resistance to change, evidenced by the system's inertia in the face of several reviews recommending reform...” (Tasmania Health Commission, 2014, p 84). This is attributed in part to a culture which is characterised by self-interest being placed before the needs of patients, poor leadership, and staff bad behaviour. Poor behaviour at the top of the system is cited as a barrier to change. A clear recommendation in this report is the need for education and training to help enact systemic change.

It is reasonable to question whether this cultural issue applies to other aspects of health and humans services in Tasmania, including disability services. It also seems tempting to question whether there is something about the characteristics of Tasmania and its systems which leads to cultures which are resistant to change.

The impact of inequitable relationships & labelling

Inequitable relationships were also identified as a significant issue in this current study, in common with Martin and Evans (1984) findings (as cited in Paterson et al., 2011), who identified particular features of services for people with disabilities which render the services susceptible to corruption. Power inequities between service users, users and staff and between levels of staff were identified in their study. As mentioned earlier, this current study identified perceptions of inequitable relationships which include bullying behaviours, control over service users, and even perceptions of pity and manipulation on the part of the service user.

This study also identified inequitable relationships between clinical staff and support staff- clinical staff identifying support staff did not have the skills to manage behaviours of concern,

including the ability to read and implement BSPs. Clinical staff also tended to point the finger at support and organisational staff for attitudes which weren't conducive to positive /person centred support.

Inequitable relationships are further demonstrated through the presence of abusive actions and restrictive practice within the sector, such as dragging service users. In these examples, from my professional practice, the worker considered it necessary and appropriate to exert physical control over the person they are supporting. In none of the examples was the action conducted for the purpose of safety of the service user. Such practices are in contravention of departmental policy, and may possibly constitute assault.

The current study revealed that 'hidden' practices were a concern- that is, things such as lack of activity provided, or lack of interaction between service users and worker. These may not be obvious restrictive interventions, but demonstrate less than optimal support practices and cultures. These are often difficult to see, however have great impact on the quality of life of the service user.

Wardhaugh and Wilding (1993) highlight the relevance of such a power imbalance. The authors make a distinction between the 'passive neglect of principles of good practice' and the 'active abuse of an organisation's position', (p 5) as well as the human rights of the person they are supporting. They highlight how corruption in organisations may occur in services designed to care for people. The authors suggest corruption is closely associated with such power and powerlessness in organisations. They also suggest that particular pressures encourage the corruption of care, such as: inadequate management; isolated organisations; absence of clear accountability; particular models of work; and the nature of certain client groups.

Wardhaugh and Wilding (1993) also identify that one of the main causes of corruption in care is the labelling of clients, as this helps to distance the client from the worker. This current study reveals elements of these issues including the labelling of clients and issues with accountability. Throughout my professional practice, I have experienced both senior and junior workers labelling service users, in ways that clearly demonstrates a lack of understanding of disability in the context of the social model.

As identified earlier, Paterson et al. (2011) make the link between corrupt cultures and the use of restrictive interventions. This helps to highlight the importance of addressing the culture of an organisation in the prevention of corruption in that organisation. This is consistent with the findings of Rickard, Chan, and Merriman (2013) who argued that addressing change in the workforce and organisational cultures is important in safeguarding the human rights of people with disability.

General community attitudes

In addition to staff attitudes, the current study reveals that general community attitudes are also a barrier to implementation of some aspects of the Act. Consistent with this, Schwatz and Armony-Sivan (2001) highlight that public attitude plays a pivotal role in the integration of people living with disability into everyday life.

The authors also raise the issue of whether attitudes need to be addressed before the integration and active inclusion of people living with disability into society, or whether actively involving people living with disability in everyday life will lead to more accepting attitudes. As such, they recommend the use of attitude assessment of workers, as a negative attitude towards those living with disability might result in the reversal of inclusive practices. Little or no community preparation has taken place in Tasmania prior to significant systemic changes, such as deinstitutionalisation, or the proclamation of a new Act. Workers are recruited from the general community- with or without training- with a high rate of turnover. Workers may not question the attitudes if they are consistent with those of the general community and if they are not provided with any training or alternatives. Community members and family members may not question practices if they have not been made aware of alternatives.

In discussing legislative changes in the disability sector, Bidemeade (1997) identified that the integration of people with disabilities has involved service providers and bureaucrats changing practices, but concludes that the success of legislative implementation depends on more than this. He identifies that legislation outlining the integration of people with disabilities assumes an accepting community "...but the notion of community as something warm and caring can be a myth...it is not uncommon for example for people placed in the community to find themselves involved in the criminal justice system simply because their behaviour seems inappropriate to the general community who may know little about disability" (p 242). Whilst attitudes may have shifted somewhat since this comment was made, it does highlight the issue that changes in law may not be sufficient to bring about changes in practice. Bidemeade (1997) provides another example, that whilst those working with people with disabilities are attempting to encourage the use of least restrictive alternatives and the promotion of dignity of risk, the courts are not necessarily familiar with these concepts. Brown (1991) (as cited in Bidemeade, 1997) highlights a case whereby a person with a disability made an adamant lifestyle choice to swim without supervision. Tragically, the person drowned one day when swimming without supervision for a short time. The Coroner stated that in spite of this person's choice, the welfare of that person was paramount, and this will sometimes require some degree of restriction to be imposed upon people with disabilities. Consistent with this, a similar issue was raised in the current study in relation to the quasi-judicial system of the Guardianship and

Administration Board (GAB). GAB are not known as ‘experts’ in the disability system, yet are required to make decisions about the application of restrictive interventions under the Act.

Similarly, as identified in the literature, other services operate from a different attitudinal and legislative base. For example, ‘support schools’ in Tasmania are obviously segregated and also have no requirement for regulation of use of restrictive interventions. It is difficult for people navigating or working in more than one system to act consistently, and expect consistency in attitudes under such circumstances. A similar issue was identified in Victoria. When asked about the impact the disability legislation has had upon the use of restrictive interventions, some responded that other sectors, such as education, not having the same requirements and understanding had adverse impacts upon their implementation of the Act (Dyson Consulting, 2012).

The impact of attitudes in general on true social inclusion-did these need to be addressed right from the start?

The social model of disability saw a worldwide shift from those individualised medical issues, to more of a view that society needs to adapt to accommodate those with disabilities. This meant greater social inclusion, rather than trying to change the person’s behaviour or individual characteristics (Price-Waterhouse-Coopers, 2011). Field (2012) concludes that in Australia, rather than enhancing the image of people with disability through increased visibility, some communities were not ready to accept those with behaviours of concern in such close proximity. Yazbeck, McVilly, and Parmenter (2004) find that in spite of advertisements, other activities, and antidiscrimination legislation, exclusionary practices still exist. The social model of disability has been highlighted as the optimal model for use with health professionals working with people with disability, in order to ensure minimisation of oppression and marginalisation (Bricher, 2000).

Forrester-Jones et al. (2006) found that social inclusion has not necessarily resulted from community care. That, instead, people with disability still mainly reside in small networks but connected to disability services. This study found that staff can often be ‘all things to all people’- including social support, provide personal care, and so on. Some of these relationships can be characterised as unidirectional relationships between staff and people being supported. These relationships are not equal. However, social interactions between staff and those they support can be enhanced through training. Johnson, Bigby, Iacono, Doubles, and Katthagen (2014) demonstrated that an educational intervention program was effective in changing staff practices and attitudes.

Kew cottages in Victoria provides an interesting example of attitudes towards integration and preparation for a service change; that is, deinstitutionalisation. “Kew Residential Services” housed four hundred and eighty people with disabilities in 2001, and almost seven hundred staff worked at the site-making it one of Australia’s largest institutions. A redevelopment of the site saw the

majority of residents rehoused throughout Victoria; approximately one hundred residents remained on the site in redeveloped cottages-the remainder was sold to the public. Community Services Minister at the time, Ms Lisa Neville, stated "...this redevelopment is one of the most positive for people with disabilities in Victoria...all residents who have moved to the new community houses across Victoria now have the opportunity to be part of their communities" (State Government Victoria, 2008, par 1). However, complaints from private residents highlight that, prior to purchasing their properties; they had no awareness that they would be sharing their complex with people with disabilities (Miller, 2008). Due to lack of preparation of the community, and continued behaviours of concern exhibited from some residents, Miller (2008) shows that the "flagship" housing project to help end deinstitutionalisation "where disabled residents would blend seamlessly in the wider community" (para 3) has not occurred as planned-for a variety of reasons. This of course begs the question of whether or not the community needed to be told; however, it is an example of attitudes existing which prevent the successful integration of those living with disabilities, particularly social integration.

When commenting about the abuse and restrictive interventions which occurred at 'Winterbourne View', a Bristol care home in the UK, Jim Mansell, who is considered an architect of services, reported that good services take time and effort to establish. Without this planning and resourcing, the wrong model of care will be implemented (Mansell, 2011). He reported that the abuse he observed in the home was a classic model of long service: unqualified strong staff that set the benchmark for other staff, through the use of physical violence. This person then expects the other staff to fall into line with their methods. The current study in no way indicate that such abuse is currently occurring in the Tasmanian disability sector; however, the study does reveal concerns about staff qualifications and their ability to seek alternatives to the use of restraint. This study also raises concerns about the CEOs and leaders of organisations, who may be well trained in financial management, but not in the support of those with disabilities. This lack of understanding may lead to services being designed for financial viability rather than person centred outcomes. This suggests that we need to encourage culture and attitudes that are optimal for the purpose.

Previous studies have hypothesised that staff regard residents of group homes positively in high performing group homes (Bigby, Knox, Beadle-Brown, & Clement, 2014). Similarly, an earlier study identified the existence of five cultural dimensions, including positive regard, and demonstrated that underperforming group homes attach more negative value to the differences people with disability exhibit (Bigby, Knox, Beadle-Brown, Clement, & Mansell, 2012). The other dimensions: alignment of power holders, orientation to change and new ideas, working practices, and perceived purpose, help to provide some structure about the questions asked in this current study about what makes a good group home.

Bigby et al. (2014) also determined that the employment of staff for reasons of attitudinal 'orientation' may be more important than other attributes such as skills and qualifications, given the importance these personal characteristics are for forming relationships with the people they support, and the contribution this has to the positive regard they hold for these people. This issue was identified in the Tasmanian sector, with some organisations identifying that they recruit on the basis of attitude and values over skill or formal qualification due to the fact the latter can be taught.

Field (2012) notes that in Australia, optimism about new models of disability care was thought to be misplaced. The same cycles of repression would occur, as the lack of finances would eventually see the burden of care transferred back to the families, who would be left with little resources to adequately care for their family member, along with a potential unwillingness to care for them. In NSW, Field (2012) notes that, during deinstitutionalisation, problems rapidly grew in group homes, staff were transferred from institutions and were experienced in behaviour management and programs of daily living. However, as the numbers of houses increased, problems increased, staff left, and were replaced by inexperienced junior staff who were largely untrained. In addition, medical specialists were no longer employed by these institutions, and the recommendation was to seek generic services for those living with disability. However, these generic services were often not willing to provide services to people with disability, and the amount of specialists in the field of disability began to decrease. Cole (2008) found that, in Tasmania, generic service providers often felt that they did not have the skills to service those living with disability, and at times cited that they were scared to do so. This has implications for the appropriate care for those living with disability in Tasmania. These issues are compounded by senior health professionals in Tasmania making recommendations for behaviour interventions that are inconsistent with contemporary practices; however, people being supported are required to consult with these professionals due to lack of alternatives. Other larger jurisdictions may have the capacity to pick and choose clinicians. This is more difficult in a smaller, more isolated place, such as Tasmania. Leadbetter and Paterson (2009) (as cited in Rickard, Chan and Merriman (2013)) highlight that difficulties in accessing specialist staff is one of the factors which works to hinder the reduction of restraint.

Upon reflection throughout my work role, I have developed some insight into the opinions of those professionals with a more medical focus. When I have relayed a particular scenario to medical professionals their responses have been interesting. This particular scenario involved a manager seeking a consultation due to her concern for some of the practices she had found existing within the institution. Some examples included that all residents were 'tied' to their commodes or the toilet during toileting with belts that were secured to the wall. The staff would leave a person on the toilet, attend to other tasks elsewhere, and go back to the person when the staff person was ready. This manager explained this procedure as 'convenient' for the staff. This led to a high level of emotion amongst those present at the seminar, who took exception to the use of 'convenience'. Clearly

defensive reactions were expressed, which demonstrated the staff's perspective, rather than the rights and freedom of the person using the toilet. Quite accurately, some pointed out that these may have been in place for reasons of safety. My point (and the point of the service manager) was that every person had these in place, these were not assessed by a therapist, and not all would require these for safety. In some cases, they were clearly in use for behavioural control.

Legislation and then change...or change and then legislation....?

The legislation regarding the use of restrictive interventions in Tasmania forces behaviour changes in those who may previously have utilised such interventions. It also seeks attitude change; however it is feasible to believe that behaviour change can occur whilst former attitudes remain. A support worker may not use restrictive interventions as they are unlawful, however may not agree with the spirit of the Act and only be acting for compliance sake. Following a literature review examining attitudes towards disability, the Irish National Disability Authority (NDA) argued that, whilst legislation compels behaviour, its impact on attitude is not immediate (NDA, 2004). The paper suggests that in the shorter term, an individual's behaviour is more greatly influenced by the surrounding attitudes, culture, and beliefs than by the new legislation. However, they suggest that, in the longer term, the legislation will change the social context and the norms and therefore eventually attitudes will change.

Bigby, Clement, Mansell, and Beadle-Brown (2009) found that whilst staff in the services which were examined agreed with principles of choice, inclusion, and participation for people with intellectual disabilities, they had issues with the application of these principles to those with more severe intellectual disabilities. The authors recommend that a conscious approach to the implementation of policy, including explicit interpretation of policy and demonstration of policy goals for staff at all levels-including senior management, is useful. The authors suggest that "seeing might mean believing for staff" (p 373). The authors also recommend the development and evaluation of demonstration programs, to ensure that best practice is disseminated across organisations. This is consistent with the current study, which strongly identified the need for senior managers to be included in policy development and implementation.

The issue of level of disability identified by Bigby et al. (2009) may also help to explain the Tasmanian support workers' reluctance to allow people living with disability to assume a level of risk- instead needing to control and supervise their lives, due to often cited 'duty of care'. Throughout the course of my professional practice, this is often claimed as a barrier to allowing people to live in an unrestricted environment. As the authors highlight, policy needs to be clear about how the principles outlined apply across a broad group of people. No distinction is made in the Act about the type or level of disability.

It is anticipated that the NDIA will help to further address attitude change, through the development of individualised plans for people living with disability, which helps to individually address the barriers to those people independently accessing their own community, leading to full integration into society. Price-Waterhouse-Coopers (2011) believed that the NDIA provides a vehicle to increase awareness and to trigger a ripple effect in mainstream culture. Their paper outlines the need for awareness and cultural change in order to make a real difference to the lives of people living with disability.

Emerging changes in the external environment (such as legislation, regulation, and emerging research) (O'Sullivan, 2008) may be present at the same time as barriers to the regulation of restrictive interventions parts of the Act, such as traditional attitudes and cultures. This culture within the sector may be a major determinant of whether or not changes are adopted; given that organisational climate is a major determinant of innovation (Panuwatwanich, Stewart, & Mohamed, 2008). This framework may help to explain the slow adoption of the legislation and associated changes. Literature regarding the diffusion of innovations suggests that a small percentage of people adopt the changes early, yet the late majority and laggards have a high propensity to resist (Rogers, 2003). Perhaps techniques to help those adopt the changes need to be addressed by the literature on innovation.

The attitude towards those living with disability may even alter, as they become seen as a commodity in the system of NDIA; perhaps perceptions might change so that those with disability are seen as contributing something positive to the community, and enabling the employment of more services and a growing industry.

Address of organisational culture is required

The success of practice change can be promoted by examining organisational attitudes and cultural change, in addition to the implementation of legislation. Consistent with this, Keski-Valkama et al. (2007) suggest that the reduction of restraint and seclusion may not be achieved simply through legislation. This study, conducted in Finland, examined nationwide trends in the use of seclusion and restraint over a fifteen year period. This included a period in which legislative changes were introduced, regarding how to report seclusion and restraint; however, this legislation did not include the explicit restriction in the use of restraint and seclusion. The authors conclude that, with such universal content, and without educational programmes or practical guidelines, cultures were not challenged, in spite of a legislative framework.

Legislation alone may not be sufficient to effect change within organisations- the culture needs to be addressed simultaneously. The culture of an organisation is intimately related to attitudes of its staff. The culture of an organisation is defined as the following: “(a) a pattern of basic

assumptions, (b) invented, discovered, or developed by a given group, (c) as it learns to cope with its problems of external adaptation and internal integration, (d) that has worked well enough to be considered valid and, therefore (e) is to be taught to new members as the (f) correct way to perceive, think and feel in relation to those problems” (Schein 1990, p 111). As such, it may be the case that organisations are attempting to prioritise the Act and models of direct service provision, however find that the legislation alone is not a sufficient means by which to do this.

Hatton, Rivers, Mason, Mason, Emerson, Kiernan, Reeves, and Alborz (1999) examined four hundred and fifty staff across services that support people with intellectual disabilities. Through this examination, they concluded that ensuring the visibility of organisational culture in services designed to support those with intellectual disability, helps the move away from blaming individual staff for high stress levels, and seeks a more systematic view of stress management. The authors also hope that such visibility will provide a method of considering the impact that changing policies and procedures have upon organisational cultures-which will have impacts for the staff and those with disabilities supported by the organisation. Culture is a key factor affecting outcomes for people living with disability who are supported by staff (Walsh, Emerson, Lobb, Hatton, Bradley, Schalock, & Moseley, 2010).

In examining a service system change, Laragy and Allen (2015) found that values, attitudes, and organisation culture required address prior to the implementation of the new system change and alongside actual implementation strategies. This study examined the transition to client directed care, or individualise care, similar to that of the NDIA. The study found that staff were unaware that they were retaining positions of power and control, and maintaining previous practices. This study demonstrates the importance of planning and education provision if change is to be achieved. Similarly, Chan (2010) argues the importance that a practice change strategy is required alongside legislation if change is to be achieved.

Throughout the course of my professional practice, some interesting observations have been made, particularly in relation to those organisations which tend to be categorised as traditional and emerging from a charitable/family basis. When examining these cultures in the context of Schein’s (1987) dimensions of organisational culture, they may be described as exhibiting a closed culture, seeking dominance over their environment, and controlling any outliers within the culture to conform to the overall norms of that culture. For example, during an educational session aimed at extending support workers' knowledge of the Act and their role within it, these organisations included the managers of the organisation. There may be many reasons for this: for example, they recognise that it is important for these people to understand the issues; however, the manner of their participation indicated otherwise. These managers tempered the comments that support workers offered in discussion, continuously outlined expectations of behaviours, advised staff to “shhhh” when

commenting on something that they might consider inappropriate. These managers also placed themselves in each group during discussions, and represented the group as the person giving feedback. Throughout discussions they, could be heard to be directing and altering the discussions, defending actions, and essentially not allowing staff to present an honest opinion/picture from their perspectives.

Now, three years after the implementation of the Act, and as recently as December 2015, through the course of my professional practice, I have learnt that senior clinicians within the departmental clinical teams do not always report the use of restrictive interventions. Reasons cited for this were that the clinicians were not sure what is and what is not restrictive, and the time isn't always optimal for this discussion. Presumably, if the clinician considered this important enough, they would re-visit the issue if uncertain at the time. However, clinicians report that these instances are often left or forgotten.

The successful implementation of legislation is reliant upon many sectors of the community becoming familiar with the ideas and intentions of the legislation; for example, organisations, governments, families, and general community members. Included in this group is boards of management. Boards may assume their organisation is on track if it is financially buoyant. Historically, boards of management of organisations consist of family members and interested members of the community (DHHS, 2015). However, there is a requirement for members of boards to be fit and proper persons, and appropriately qualified, with the organisation determining what might meet this definition. There has been no emphasis on clinicians or those with particular philosophical understandings to be part of boards, therefore the boards may have no particular interest in the philosophies of service delivery or be concerned about the organisation's performance in this area. This study highlights the importance of all elements of the sector possessing consistent attitudes, in order for the Act to be implemented consistently. If the sector were prioritising the aspects of the Act which related to support models, and ultimately the reduction of use of restrictive interventions, greater attention may be given to this.

Below is a case study outlining an innovative approach to ensuring boards of management are equipped for the introduction of NDIS.

New Board of Management, increase in governance

The CEO of a tier II disability organisation, which provides advice and education to people with a certain disability type, saw the need to make some changes in their governance structure, in order to be NDIA ready.

The CEO of this organisation realised the strategic plan which had been developed in order to assist readiness for NDIA, required a different skill set to that which existed on the Board of Management (BOM). The CEO subsequently highlighted to the BOM a cultural change was required. Operating from a framework consistent with the Policy Governance model (Carver, 2015), this CEO saw the need for the BOM to have a greater role in governance, and less of a role with the operational aspects of the organisation.

In recognition NDIA will require a different level of accountability going into the future, different skills were required in the Board members. This led to the recruitment of BOM members with marketing, legal, political and IT backgrounds. The organisation also saw the need for a Medical Practitioner, however, were unable to attract someone to this position. These new members replaced those members who come from a charitable, operational philosophy.

In recognition the new framework challenges those not for profit organisations to be more accountable, younger board members are encouraged to undergo training with the Australian Institute of Company Directors (AICD) to assist in their development.

With greater capacity to have a governance role in differing areas of responsibility and expertise, the delegation of operational responsibility has been made to the CEO. Clear reporting lines, areas of expertise and responsibility and greater level of governance have so far shown to assist in the organisation be confident they can deliver a good quality service going into the future.

In order for this to occur, this required the CEO to recognise the requirements of the new system and compare those to the existing expertise. This then required the CEO to provide this knowledge to the BOM with the view to demonstrating change was required.

In summary, this study shows the need for continued attitudinal change, in order to effectively implement the requirements of the Act. The literature around service system changes highlights the benefits of planning service system changes, and in doing so, addressing attitudinal change specifically. The sufficiency of the legislation in the face of this will now be addressed.

Is the Legislation sufficient?

Legislation alone may not help to address the issues of organisational culture and change. However, Chan, Webber, and French (2014) found that legislation is a critical starting point for the protection of rights of people living with disability. Bigby (2007) believes that the promotion of the rights of people living with disability relies on the long term sustained implementation of policy and the necessary resources by which to do this, in addition to a strong commitment from both the government and non-government sectors, rather than a reliance on the policy and associated rhetoric. As identified earlier, Chan, Webber, and French (2014) attribute the success of the Victorian disability legislation to the broader systemic response the legislation facilitated, and also to the skills and powers of the Senior Practitioner and team.

Victoria is the first Australian state to implement legislation in this area, and they have developed strategies to complement their legislation and to ultimately reduce and prevent the use of restraint and seclusion. These four main strategies are:

- (1) Leadership for organisational change
- (2) Use of data to inform practice and policy
- (3) Workforce development
- (4) Use of restraint and seclusion reduction tools (Chan, Webber, & French, 2014).

As identified by the authors, these are similar to the core strategies recommended by Azeem, Aujila, Rammerth, Binsfeld, and Jones (2011) and Lebel, Huckshorn, and Caldwell (2011), which form the basis of the national recommendations for the reduction of restrictive interventions, recommended for implementation when NDIS is implemented (DPRWG, 2011).

The strategies implemented in order to support the legislation have had the effect of reducing the incidence of use of restrictive practices in Victoria, although they state this has been a modest decrease over the first 4 years of implementation (Chan, Webber & French, 2014). The resources made available to help achieve this are a highly specialised group of people with skills in research, systems management, allied health, clinical and forensic psychology (Webber, Chan, & French, 2014). It is possible, in the Tasmanian example, that the existence of legislation (and legislation that includes the explicit reduction of use of restrictive interventions) and resources provided is not sufficient motivation for people to comply with its requirements.

As identified in literature review, Leadbetter and Paterson (2009) (as cited in Rickard, Chan, & Merriman, 2013) argue that there are many factors that present as risks to the minimisation of the use of restraint- so that mandating the reduction is not always sufficient. There are key components which need to be addressed in order to reduce the use of restraint- even in the face of legislation. The authors identify the following requirements in addition to legislation: “The law is only one, though cultural, feature of protection; practical change among the workforce and organisational culture is a very important element to safeguard the rights of people with disabilities” (Leadbetter & Paterson, 2009; as cited in Rickard, Chan, & Merriman, 2013).

Sabatier and Mazmanian (2005) argued that the literature outlining policy implementation is quite pessimistic about the potential for social changes to be effected by such policy initiatives. The authors believe that the following conditions need to be met in order to effectively implement policy:

- (1) it is based on sound theory relating to the achievement of objectives;
- (2) the statute is unambiguous and contains directives regarding the implementation process.

This emphasises the importance of activities occurring alongside the implementation of legislation in achieving compliance and a reduction in the use of restrictive interventions. The Tasmanian Act has been in place for a relatively short amount of time, and the role of senior practitioner an even shorter amount of time. It may be reasonable to expect a greater compliance rate as the effects of complementary activities continue to be realised. Indeed, other research highlights the need for a range of strategies. Deveau and McGill (2008) also recommend strategies, such as leadership and organisational change, active monitoring, the use of data, specific restraint reduction approaches, and the involvement of providers, commissioners, and inspectors.

The sufficiency of the content of legislation is also a potential issue hindering the effective implementation of an Act. There is a vast difference in people’s understanding of the Act and their role within the Act. Such variations will occur due to a variety of reasons, for example differential participation in activities aimed at helping stakeholder understand the requirements.

Rickard, Chan, and Merriman (2013) also identify that the implementation of new policies associated with the reduction of use of restraint can be difficult. A major issue they identify is the operationalisation of a definition of restraint, and the application of this definition to a heterogeneous group in the context of service providers developing their own policy. The authors suggest that this gap between policy and practice should be addressed by stronger regulation. Indeed, a review conducted in Victoria into the impact of the *Disability Act 2006* (Vic) on community sector organisations revealed the need to ensure that policies were reviewed to ensure clarity of intent and definition (Dyson Consulting Group, 2012).

A potential issue in understanding and implementing the Act is the distinction which the legislation makes between those who receive state funded care and those who do not. This is common to all jurisdictions with legislation regulating this area (Chandler, Willmott, & White, 2014). This perhaps hinders the consistent application of legislation, and may lead to inequitable experiences for people with disability.

The current study, consistent with others, identifies that the unclear definitions contained within the Act contribute to difficulties understanding and interpreting the Act. In Ireland, for example, it is argued that the definitions of mechanical restraint are not prescriptive enough (Rickard et al., 2013). In Tasmania, there is discrepancy between what constitutes an environmental restriction and what constitutes physical restraint (in particular seclusion and containment). These definitions are different to those used in most other jurisdictions. Chandler, Willmott, and White (2014) highlight the importance of having a nationally consistent approach for a variety of reasons-that shared definitions enable comparisons as well as a shared body of research would be one of those reasons. Similarly, in Tasmania, confusion also exists over the definition of what is therapeutic and what is restrictive, given there is no definition of “therapeutic” in the act or in *Acts Interpretation Act 1931* (Tas). The term therapeutic may be interpreted differently in behavioural fields in comparison with medical fields-therefore, attempting to use a commonly understood definition of this term becomes problematic.

In Australia, there is currently a debate about the way in which restrictive interventions will be regulated within the NDIS framework, as well as the specifics about the quality and safety framework, given that specific state legislation will not apply in a national funding framework. There is also debate about whether or not there will be a prescribed decision making process; thus, there may be explicit legal protection for the rights of participants or the service provider. This consideration and review of arrangements allows for the consideration of the issues raised in the literature, which lead to barriers of the implementation of requirements for the reduction of restrictive interventions.

The impact training and education in the sector has upon the ability of the sector to implement the changes required in order to implement the Act.

The current study, consistent with other studies, found that that staff require a particular set of skills in order to reduce the use of restrictive interventions. This study also revealed that participants believed that organisational staff within Tasmania do not have those necessary skills.

A significant amount of skill is required to adequately support a person living with disability, in accordance with the Act. Participants of this study believed that the bulk of this responsibility falls to support workers, although acknowledged the role of clinicians, leaders, and managers of

organisations. Included amongst this skill set is the ability to understand person centred support and positive behaviour support, including understanding and implementation of BSPs. In Tasmania, there is some training provided by the government/funder around the alternatives to the use of restrictive interventions. Organisations are also able to decide what type of training is provided for their own staff. For example, I discovered, through the course of professional practice, that one organisation sought training from a martial arts instructor about how to break away from aggressive people being supported, and break any holds the person may have over staff. This was not one of the more recognised Proactive Response Approach (formerly Physical Assault Response Training (PART)) training sessions, which included a component of positive behaviour support-but simply a martial artist. This is an interesting choice of training when perhaps training in the prevention of the behaviour is available for staff. If members of boards and managers are not specialists in the field, then organisations are not necessarily able to make decisions based on best practice without external consultation. In the example of the above organisation, this was seen as the most appropriate way to protect staff.

Also consistent with other studies, organisation support staff do not believe that they have the skills necessary to reduce the use of restrictive interventions. McKenzie, Rae, MacLean, Megson & Wilson (2006) found that support staff may lack the skills, experience, or training to manage challenging behaviour safely and effectively. Similarly, clinical staff in the current study believed that the support staff do not have the necessary skills.

In the current study, clinical staff were seen as a resource to help the support staff, both in the development of positive BSPs and also in training support staff. However, as mentioned earlier, a skills audit conducted in late 2014 throughout the course of my professional practice identified that only approximately one third of the clinical teams have formal training in positive behaviour support. None of the respondents received positive behaviour support training through the course of their university degree equipping them for their professional role.

After considerable debate, I was successful in gaining agreement to provide training in how to write and assess BSPs for the department's clinicians. This training was provided in April 2015, and well received by the clinicians. This training was provided by an experienced academic based in Victoria. Interestingly, however, when asked at the conclusion of the training whether they considered it their responsibility to write BSPs, not all agreed. This apparent role confusion exacerbates confusion within the sector around this issue.

Further consistency was found between the current study and existing studies. Without appropriate training the sector is unable to successfully implement the requirements of the Act, more specifically, to reduce the use of restrictive interventions. Nunno, Holden, and Leidy (2003) also found that without adequate training, staff are more likely to use violent methods to address

behaviours of concern such as aggression. In a therapeutic care residence supporting children, Nunno et al. (2003) found that appropriate training for staff can reduce the use of physical restraint and reduce aggressive behaviours of concern. Rimland (2011) also suggested that education and training has been identified as one of the main barriers to the reduction of restraint. Similarly, Webber, Chan, and French (2014) found that one of the keys to successful implementation of the *Disability Services Act 2006* (Vic) was educational programs, including online courses teaching positive behaviour support.

It is necessary for support staff to have a basic understanding of the concept of a function of a behaviour, and how a functional assessment of behaviour is conducted. The literature clearly identifies current thinking about the aetiology of behaviours of concern. For example, LaVigna and Donnellan (1986) identify that behaviour results from an interaction between a person's disability and their environment, and an examination of this can help to understand the reason for behaviour. Ultimately, an understanding that behaviours of concern are an expression of a need, that is, that these behaviours have a communicative intent, is a necessary starting point for staff to manage such behaviours in a positive manner, without the use of restrictive interventions. Positive behaviour support strategies are associated with declines in the incidence of behaviours of concern (LaVigna & Willis, 1995). If staff do not have access to strategies and procedures which reduce incidence of challenging behaviour, this becomes dangerous for them and for others around the person who is exhibiting the behaviour. LaVigna and Willis (2005) outline a model whose purpose is to facilitate a functional analysis and subsequently produce a plan to address the behaviour; that is, designed to address behaviours of concern and increase a person's quality of life through assisting the person to access more social and community activities. To use the example of the young person being secluded on the balcony of their house following outburst behaviours, if the staff of this organisation understood that this behaviour was communicating a need, without an examination of that need, it is unlikely that they would have secluded the person from staff and housemates. Instead, this would be seen as a form of punishment in an attempt to modify behaviour.

Previously, the Tasmanian service system conducted such training for support staff, managers, and clinical staff. Since the implementation of the Act, this has not been available in such a structured manner. Instead, each individual service is expected to access (fund) this training, or for the clinical team to provide it. This study found that the clinical teams are unsure whether this is a function they should be conducting. The previous structured approach to training was not sustainable. Crates and Spicer (2012) identify that, in Tasmania, the largest barrier to this program continuing was the sustainability of the training team in a relatively small service system, as well as maintaining the integrity and quality of the program. Regardless, this appears as a priority for none of the teams. There are currently relatively few people within community service organisations who are trained to

conduct a functional analysis, necessitating reliance upon the government clinical team. As only one third of these team members are trained in positive behaviour support it is concerning that a sense of urgency to have clinical staff trained appears to be absent.

The study conducted by McKenzie et al (2006) examined periodic service reviews to determine the extent to which services carried out their behaviour interventions. Some services were given formal guidelines for behaviour intervention written by a health professional. The results of this study demonstrate that even those given formal guidelines were unable to identify target behaviour and record it appropriately. This is consistent with findings in Tasmania that demonstrate that, even when an intervention program is devised, support staff have difficulty executing the plan. Similarly, through professional discussions with OSP Victoria, it is clear that members of the Victorian sector identified difficulties understanding the function of a behaviour- this therefore became the focus of their training sessions. It is clear that these are specific skills which require training in Tasmania.

The literature suggests that improving this understanding in staff can be both the most important and most difficult to implement, as some see this as a major concept shift (Nunno, Holden, & Leidy, 2003). It is clear from the above discussion and the results of this current study that this concept has not yet been fully adopted by the Tasmanian sector. Several examples have been cited already- such as the description of behaviour as “offensive” rather than considering a function that this behaviour might serve, and a senior manager’s description of behaviour as “bullying”. These examples demonstrate a misunderstanding of the reason people with disabilities exhibit behaviours of concern. Throughout the course of my professional practice, I encountered many examples such as this. As identified earlier, such labelling may exemplify at best an ignorant, and at worst a corrupt culture within the organisation.

This study shows that many staff had no idea about the contents of the new Act, let alone the opportunity to participate in the training sessions provided. It is likely that this area of change had not been prioritised. Those involved in the of the Act have issues with the clarity of the Act definitions and so, clinicians and support staff are left confused about what constitutes a restrictive intervention and what do not.

Consistent with findings of the current study, Wardhaugh and Wilding (1993) argue that it is a universal fact of service provision that support staff have the most difficult job, yet are the least trained, supported, and paid. They state that in many situations, staff are out of their depth. Due to a lack of resources, the reality of practice is quite different to the ‘rhetoric’ of policy, and staff are under huge pressures. If services are unsafe for staff, then without adequate training or support, the needs of the service user become secondary to those of the staff (Paterson, 2011). This current study clearly identified that the staff felt ill equipped to manage behaviours of concern, or implement alternatives to

the use of restraint. It may therefore follow that the needs of the service user are coming second to the needs of the staff, to manage their shift and maintain their own safety.

Chapter 5 in brief

People with disabilities largely rely on those who support them to help enhance their quality of life. The extent to which disability support workers are able to do this depends upon their skill, their attitudes, and the structures in place to enable best practice support. This chapter outlined some of the issues which prevent best practice support in Tasmanian disability services. The new legislation aims to encourage this best practice, that is positive behaviour support, person centred support, and the minimisation of use of restrictive interventions. This chapter outlined the barriers to the implementation of part 6 this legislation, as it relates to the regulation of restrictive interventions- namely lack of prioritisation of the legislation, attitudes, skills, and training of Tasmanian workers and issues with the legislation itself.

Amongst these findings is the reflection of the belief that people with disabilities still have inequitable status in the community. As a result, the implementation of the Act takes a low priority for specialist disability services and, as such, training is not provided, cultures are not examined, and adequate structures around the implementation of the Act are not provided.

The next chapter provides some recommendations for the Tasmanian disability sector in light of these findings.

Chapter 6.

Conclusion & Recommendations

Chapter 6.

Conclusion & Recommendations

Restrictive interventions continue to be used in disability services in Tasmania as well as Australia wide, in spite of well-established evidence regarding the risks of the use of such interventions. In Tasmania, the *Disability Services Act 2011* (Tas) (the Act) includes provisions for the regulation and obviation of the use of restrictive interventions (part 6). This study aimed to determine the extent to which these sections of the Act had been implemented, given the suggestion that restrictive interventions are still used within the sector. The thesis aimed to determine the barriers to the implementation of the Act and the reduction of use of restrictive interventions. The disability service system is set to change nationally, due to the implementation of the National Disability Insurance Scheme. This study therefore sought to determine the positioning of the Tasmanian sector in terms of the philosophies, preparedness, and compliance with regulatory requirements. This study sought to provide recommendations for preparation for this systemic change to help implement this successfully. These recommendations are considered timely, in light of NDIA considering the quality and safety framework for the scheme, including how to regulate and monitor the use of restrictive interventions.

The results of this study indicate that the Tasmanian disability sector is not adequately equipped to reduce the amount of restrictive interventions as required by the Act. Barriers to the implementation of the Act lead to the continued use of restrictive interventions within the sector. The extent to which those interventions are used is difficult to quantify under the current reporting arrangements; however, participants in the sector overwhelmingly indicate that they do not have sufficient understanding of the Act and how to implement it.

The evidence provided in this study shows that there are specific issues within Tasmania which need to be considered when implementing an Act or framework such as this. Tasmania lags behind, both historically and currently, in the implementation of service system changes. For example, in deinstitutionalisation and in increases in the rates of seclusion in mental health services. Both health and human services within Tasmania have demonstrated resistance to change. A specific focus on addressing the negative effects of the current culture is required. This study highlights the Tasmanian disability system is characterised by a culture of wariness, where leaders of organisations believe people with disabilities and behaviours of concern to be exhibiting bullying behaviour, and who find behaviours of concern “offensive”. The results of this study shows inequitable relationships characterise the current system, as evidenced by examples of abusive and inappropriate behaviour occurring within a broad range of organisations. This study identifies a culture whereby it is perceived, by elements of the disability sector, that people with disabilities have poor status in their communities, and, as such, aspects of the legislation may not be prioritised for implementation.

Throughout this study it is shown in Tasmania there is a perception that if such restrictive interventions are being used, this will have little impact on society- because “...the power station won’t fall over and the screams won’t be heard”. The Commission on Delivery of Health Services in Tasmania (2014) also notes that systemic and structural changes must be underpinned by changed attitudes and actions. This is relevant when considering the implementation of the systemic changes for Tasmania in the introduction of NDIS.

It is a risk that the new system may not effect significant change in a jurisdiction such as Tasmania. The choice and control which participants will have in the scheme will help to ensure that only high quality services remain viable in jurisdictions. However, it remains to be seen if Tasmania has the population size to sustain such a market-driven disability system, or if more of the same will be the result. Tasmanian organisations struggle to find suitable staff, particularly in rural areas; we have amongst the highest rate of disability and poor literacy rates. These factors may deter new organisations entering the service system. It may be the case that Tasmania has the same specialist disability services that do not evolve, rather than the hopeful change the NDIS promises.

The success of a service system is dependent on the workers in the system. A new service system will not be successfully simply by virtue of the fact it is new and improved. The NDIS will still require skilled staff with attitudes consistent with person centred and positive behaviour support. This study demonstrates there is substantial work to do in this regard.

1. It is therefore recommended that a focus on Tasmanian cultural change is considered alongside and irrespective of the implementation of the NDIS. The targets of such change should include support staff, leaders, managers, board members, and clinicians. Ideally, a cultural assessment of current organisations and indications for areas of change could occur, similar to the cultural mapping project being undertaken for the NDIA itself. Organisations could determine the required areas for change to be effective specialist disability support organisations in the future. Their adaptation could be utilised as a marketing tool to attract business once NDIS is implemented.
2. It is understood that some work has commenced through National Disability Services in terms of person centred support. This is one aspect of cultural change, but additional aspects need to be included. An assessment of the impact of any work around cultural changes should be assessed for efficacy.

As the Victorian Office of the Senior Practitioner found, good quality support is characterised by a reduction in the use of restrictive interventions, and is best achieved through a structured

response, made possible through the legislation. The NDIS is currently examining quality and safety frameworks, and the best methods to balance a system of choice and safety. There is debate about whether or not legislation should be replaced by voluntary codes. It is difficult to see how a system using reliance on voluntary codes can have the same leverage as legislation. Still, in the face of legislation and its leverage to help force compliance, the sector has difficulty reducing the use of restrictive interventions. This study shows that when it comes to the issue of restrictive interventions, leaders and managers obfuscate their responses, are reluctant to information requests, and appear not to understand the intricacies of person centred care or positive behaviour support. In addition, Boards of Management do not typically seek reports regarding methods of support or client outcomes. It is therefore difficult to determine whether, if the system is changed to voluntary codes, good compliance would result.

3. It is recommended that the monitoring and regulation of restrictive interventions remains a legislated issue, with increased compliance measures put in place to achieve greater adherence to such legislation. An integral aspect of this is to help determine the processes and procedures for enforcing penalties for breaches, and start to use these as appropriate. This may help to minimise the perception that the department has no mandate to enforce change.
4. A further recommendation in this regard is that particular focus should be given to board of management accountability for the reduction of use of restrictive interventions. Those responsible to the board should be required to report on the goal of reduction of use of restrictive interventions within that organisation. It is recommended that boards of management undergo specific education and training about the issues associated with the use of restrictive interventions. Governance structures within organisations need to set goals around outcomes for people being supported, and examine the achievement of these goals, rather than being focused solely on the financial viability of their organisation.
5. Boards of management might consider the skills of board members, and consider the need for those with clinical skills, for example, to help assess client outcomes as reported to the Board.
6. It is recommended that other systems of governance are strengthened. The role of Authorised Officer needs to be progressed and implemented.

7. Compliance regarding the development of individual plans needs to be monitored and addressed. These plans are seen as the platform from which to provide person centred support, as well as provide some context for the development of a behaviour support plan, if required.

As stated earlier, this current study supports the view that a system relies upon the skill of its workers. The study reveals some concerns about the ability of those currently within the sector to reduce the use of restrictive interventions as per the Act. It is unclear to the sector whose responsibility it is to provide such training, and whose responsibility it is to write behaviour support plans (a necessary factor in the consideration of reduction of use of restrictive interventions).

This study also demonstrated that it should not be assumed that clinical staff fully comprehend the issues associated with restrictive intervention definitions and alternatives to the use of restraint.

8. It is therefore recommended that it be a requirement for staff working in the sector to participate in positive behaviour support training. This is particularly relevant for direct support workers and clinicians, but also leaders and managers of organisations. A greater emphasis on this should be given by registered training organisations and in recruitment of staff.
9. Ongoing training in the development of behaviour support plans should be provided for the clinical teams. These teams should make a determination they will in turn provide this training for the broader community service sector. Without their assistance, it is unlikely that the organisations will be able to access such training (for reasons of cost and availability).
10. Ongoing training around alternatives to the use of restrictive interventions should be accessed by departmental clinicians.
11. Ongoing training should be accessed by departmental clinicians around the risks to the use of restrictive intervention, given that staff report turning a blind eye to these at times.

It is important to have legislation in place to provide a framework for the regulation and monitoring of use of restrictive interventions, and to guide people's roles through the use of such a legislative framework. However, this study indicates that legislation alone is not sufficient to bring about the

necessary changes required to be in a position to claim that an act is fully implemented. In support of the findings of Chan (2010), this study also highlights the need for good operationalisation of Part 6 of the Act, to ensure that all parties understand definitions, philosophies, and roles under the act. This study provides evidence that the clinicians required to be experts do not fully understand the definitions under the Act, making practice difficult for them and for organisations reliant upon their advice.

12. It is recommended that the Act be operationalised further. This operationalisation should include the development of definitions, practice standards, and guidelines.

To be more specific, the following are recommended:

- (i) Clear key definitions including the meaning of ‘therapeutic purposes’ should be developed and disseminated to all, particularly clinical staff
- (ii) Additional fact sheets should be developed, for example those detailing procedures to encourage less restrictive options (see appendix J for example)
- (iii) Protocols for clinicians regarding their responsibilities under the Act
- (iv) Clearer definition information, including guidance around chemical restraint
- (V) Standards for common practices should be developed and staff trained in accordance with these. This should include best practice treatment for some disorders which are commonly subjected to the use of restrictive interventions.

For the first time, this study provides an examination of the Tasmanian disability service system and its approach to the regulation and monitoring of the use of restrictive interventions. In addition, it provides some insight into the perceptions of the participants in that service system, about their readiness to implement the legislation which is providing a framework to help reduce the use of such interventions. This study also provides some insight into the reasons that restrictive interventions are still utilised in this sector and recommendations to overcome the barriers to its minimisation.

Appendices

Appendix A

Online survey

1. Have you read the information sheet attached to the accompanying email?

- ☐ Yes
☐ No
☐ Dont Know

2. What is your position within your organisation?

3. Does your service have a policy document about the use of personal restraint?

- ☐ Yes
☐ No
☐ Dont know

4. Does your service have a policy document about the use of environmental restraint?

- ☐ yes
☐ No
☐ Dont know

5. Do any of your direct support staff ever attend training in personal restraint techniques?

- ☐ Yes
☐ No
☐ Dont know

6. Do any of your direct support staff ever attend training in environmental restraint techniques?

- ☐ Yes
☐ No
☐ Dont know

7. Describe your understanding of "personal" restriction

8. Describe your understanding of "environmental" restriction

9. Do support workers in your organisation receive training in any of the following?

	Yes	No	Dont know
Behaviour support plans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Positive behaviour support strategies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Human Rights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
De-escalation techniques	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal aspects of restraint use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ethical aspects of restraint use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Duty of care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
reasonable force	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
least restrictive alternatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Risk assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Risk management techniques	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Techniques for safe disengagement and personal protection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Systematic recording of incidents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Debriefing procedures for staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mindfulness training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PART (or similar)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*** 10. How many service users have individual plans that include processes for the use of environmental or personal restraint (approximately)?**

Appendix B

Focus group questions

1. What are the benefits of legislation such as the *Disability Services Act 2011*(Tas)
2. What are the disadvantages
3. Do you see there have been any barriers to the implementation of the Act
4. What are these, if any?
5. How might these be overcome

Appendix C

Checklist of practices

Holding from behind by crossing a person's arms over their chest and restraining

Restraining a person to the floor face up

Physically escorting a person to another area while restraining their arms

Restraining a person to a chair or in a sitting position

Breaking away from grabs/attacks/kicks

Locking doors to prevent access

Containing a person within a certain restricted area

Withholding a valued item or activity to change a behaviour

Increasing supervision to change a behaviour or to minimise risk

Appendix D

Written compliance letter

Department of Health and Human Services

DISABILITY, HOUSING AND COMMUNITY SERVICES - HOUSING TASMANIA

GPO Box 125, HOBART TAS 7001 Australia



Contact: Kristen Foss
Phone: (03) 6233 3120
Facsimile: (03)
E-mail: kristen.webb@dhhs.tas.gov.au
File:

Dear

As you will be aware, the *Disability Services Act 2011* (Tas) provides for the regulation and monitoring of restrictive interventions. A disability service provider or funded person must not carry out, in relation to a person with a disability who is under their care or control, a restrictive intervention unless there is an approval under section 38 or 42 of the *Disability Services Act 2011*.

The position of Senior Practitioner has been established under the *Disability services Act 2011* a primary function of this position is to authorise and monitor the use of restrictive interventions in Disability and Community Services provided or funded services. This position has been in place for 12months.

Two years into the operation of the new Act I am writing to ensure that your organisation is currently being compliant with part 6 of the legislation. Accordingly, could you provide written feedback to the following questions:

Does your organisation have restrictive interventions in place?

Which of these restrictive interventions have approval under section 38 or 42, please list.

Does your organisation have policy relating to the use of restrictive interventions?

Does your organisation provide training for staff regarding alternatives to the use of restraint?

Do you think the leaders and managers within your organisation as well as your staff understand the issues regarding the use of restrictive interventions and their requirements under the act?

If you are not able to answer these questions, or would like assistance from the Senior Practitioner, please contact Kristen Foss on 62333120 or email Kristen.webb@dhhs.tas.gov.au

These questions may not be relevant to you, for reasons such as your organisation does not provide direct support to people with disability. If this is the case, could you please respond outlining the reason this is not relevant.

Could you please provide a response to this letter by 30 January 2014.

Director

20 November 2013

Appendix E

Ethics application



HUMAN RESEARCH ETHICS COMMITTEE
(TASMANIA) NETWORK



SOCIAL SCIENCE HREC
AMENDMENT TO APPROVED PROJECT

This form should be completed to apply for amendments to all types of applications previously approved by the Social Science HREC.

Important: Please send an electronic version of this form as a Word document along with the attachments indicated below to katherine.shaw@utas.edu.au.
A signed copy of this form also needs to be forwarded electronically.

If you have any questions, please call: 6226 2763

Ethics Reference Number	H12443	Date:	22/10/12
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1. Title of approved project

A national comparison of models of intensive support

2. Investigator names

Chief Investigator	Stella Stevens
Phone:	03 62264683
Email:	Stella.stevens@utas.edu.au
Other Investigator	James Vickers
Phone:	03 6226 4830
Email:	James.vickers@utas.edu.au
Other Investigator	Kristen Webb-Foss
Phone:	0364344103
Email:	Kristen.webb@dhs.tas.gov.au

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If you answered 'YES', please identify these issues below:
Ethical issues will be very similar to those in original application and therefore managed with the same processes.
Participants may feel adversely affected when answering questions about the use of restrictive practices. This may be as they are recalling a distressing event, or feel something adverse about their organisation using the practices. Identifying information will not be sought or allowed for in the questions.

6. Do the information sheet and/or consent form need to be changed? Yes ☒ No ☐

If you answered 'YES', please attach new information sheets and consent forms. Track changes must be used when making changes to previously approved documentation. Your amendment can not be assessed if Track Changes is not used.

7. Signatures:

Chief Investigator Name:	
Chief Investigator Signature:	
Date:	

References

Deveau, R., & McGill, P. (2009). Physical Interventions for Adults with intellectual disabilities: survey of use, policy, training, and monitoring. *Journal of applied research in intellectual disabilities*, 22(2), 145-151.

Foss, K. A. (2010). *A review of the intensive support service policy and procedures*. Unpublished master's thesis. University of Tasmania. Hobart.

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3. Requested changes to project

(These may include, for example, changes in procedure or direction of the project, changes to research personnel, changes in the source or manner of recruitment, or changes in the number of subjects.)

An additional aspect of the project is proposed. That is, a second group of subjects invited to complete a survey via survey monkey. Additional subjects will be recruited by identifying Community Service organisations who receive funding from Disability and Community Services (Tasmania). Organisations will be identified through the public department website, which lists the organisations. An invitation, information and consent form will be sent to the Manager of each organisation by way of invitation to participate. Subjects will be asked to answer a series of questions relating to the organisations use of, policy relating to and training around restrictive interventions, based on a survey developed by Deveau & McGill (2009) (questions attached).

4. Justification / reasons for the changes

Tasmania's service system has changed since original proposal and the introduction of new legislation passed late in 2011 (Disability Services Act). This legislation included the introduction of a position of Senior Practitioner to monitor restrictive practices amongst funded disability services. The determination of the extent of the use of restrictive practices is necessary when making recommendations for best practices for intensive support (as per intention of original study). A baseline of these practices and associated training and policies needs to be determined in order to determine the best approach for Tasmania with regard to training, application processes and staff development when managing people with disabilities and behaviours of concern. One of the aims of the original project was to determine the best practices in relation to governance over the intensive support system. The need for greater systems of governance in Tasmania was identified by Foss (2010). The position of Senior Practitioner provides the governance of the use of restrictive practices, on behalf of the secretary of the department, therefore baseline data will be vital in determining what the sector requires in order to improve and develop.

The reduction in the amount of national services to be examined is two fold: (a) due to the introduction of the above aspect of the study; and (b) the states chosen (NSW, VIC, QLD) all have senior practitioner positions and legislation that prohibits the use of restricted practices - they are therefore more closely aligned to Tasmania's legislation, allowing for more useful comparison and recommendations for best practices.

5. Do the changes raise any ethical issues? Yes ☒ No ☐

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Survey Questions

Personal & environmental restriction practices in disability services

- Have you read the information sheet attached to accompanying email
- Does your service have a policy document about the use of personal restraint
 - Yes No (if no skip to next section)
- Environmental restraint
 - Yes No (if no skip to next section)
- Chemical restraint
 - Yes No (if no skip to next section)
- Do support workers receive training in any of the following?
 - Behaviour support plans
 - Positive behaviour support strategies
 - Human rights
 - De-escalation techniques
 - Legal aspects of the use of restriction
 - Ethical aspects of the use of restriction
 - Duty of care
 - Reasonable force
 - Least restrictive alternatives
 - Risk assessment
 - Common risk factors and contraindications for using physical restraint including potentially dangerous or fatal postures and positioning
 - Specific cultural, gender and/or age related issues that may affect how physical restraint should or should not be used with individual clients
 - Risk management techniques
 - Techniques for safe disengagement and personal protection
 - Systematic recording of incidents
 - Debriefing procedures for staff
 - Medication training
- How many service users have individual plans that included processes for the use of personal, environmental or chemical restraint.
- Are any of the following techniques used by staff in your organisation
 - Holding from behind by crossing a person's arms over their chest and restraining
 - Restraining a person to the floor, face up
 - Physically escorting person to another area while restraining their arms
 - Restraining a person to a chair or in a sitting position
 - Locking doors to prevent access
 - Containing a person within a certain restricted area
 - Withholding a valued item or activity to change a behaviour
 - Increasing supervision to change a behaviour or minimise risk
 - Giving of medication to change a behaviour or minimise risk

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National comparison of models of intensive support

1. Invitation

You are invited to participate in a study being conducted in Tasmania examining nationwide models of support for people with intellectual disabilities and challenging behaviour. This study is being conducted in partial fulfillment of a Doctor of Health for Kristen Foss under the supervision of Dr Stella Stevens (Associate Head, Postgraduate School of Medicine, University of Tasmania) & Professor James Vickers (Head, School of Medicine, University of Tasmania).

2. What is the purpose of this study?

The purpose of this study is to collate information about the models of intensive support that might exist nationwide, including exploring the issue of restrictive practices. The study will compare these models and aim collate the information into a synthesis of best practice for working with clients with challenging behaviour and intellectual disability-whose needs sit outside the mainstream government systems. The purpose of this is to determine any best practices that exist.

3. Why have I been invited to participate?

You have been invited to participate in this study due to your position within your organization and association with such models of support, as described above, or your manager has identified you as the most suitable respondent..

Your participation in this research is entirely voluntary. There will be no consequences if you decide not to participate. Your manager, who identified you as a suitable participant, or anyone within your organization, will not be advised.

4. What will I be asked to do?

If you agree to participate, you will be asked to complete an online survey. This survey will include approximately 20 questions about your organizations experiences with the management of challenging behaviour. More specifically, the practices of personal, environmental or chemical restrictions. The survey will take approximately 15 minutes to complete. You will be asked to provide information about your organization, not personal information about your own practices.

You do not have to participate, if you decide not to, this will not affect your employment or relationship with UTAS.

If you start to participate and then change your mind, that is OK. The information that you have provided thus far can either be given back to you or destroyed, depending on what you want.

5. Are there any possible benefits from participation in this study?

The aims of this study are to improve those services in which we work. It is hoped that through participation in this research effective aspects of models can be collated and highlighted so that services may use this information for planning and evaluating services. Your participation in this study will assist greatly in providing such information for collation.

6. Are there any possible risks from participation in this study?

The questions that will be asked in this research project will be designed to elicit information about the processes, procedures and theories behind the models of support rather than specific information that might lead participants to feel anxiety or distress. However it may be the case that specific instances of challenging behaviour or a client circumstances is recalled throughout this interview process. It is possible this might lead to distress.

In the event that any anxiety or distress is exhibited by you, You have the right to stop the survey process without giving a reason. There will be no consequences if you choose to terminate the interview process.

If you or the researcher consider that a referral is required to help address any distress experienced, the researcher will assist you to seek appropriate support. This will depend on what is available in your state.

7. What if I change my mind during or after the study?

At any stage throughout this research, you may decide to withdraw. You will not be obliged to provide any explanation if you choose to withdraw. The information that you have provided thus far can either be given back to you or destroyed, depending on what you want.

8. What will happen to the information when this study is over?

All data collected will be treated in a confidential manner. Names and identifying information is not required for the purpose of this study, however due to the relatively small size of disability services, some of your comments may be attributable to you or your state. Every attempt will be made to keep identifiably to a minimum.

All of the information will be kept in a locked cabinet in the office of Dr Stella Stevens, who is Kristen's supervisor, at the University of Tasmania. Kristen will keep some password protected electronic data until the review completion. All of this data will be kept for 5 years and then destroyed. The written transcripts will be shredded and the electronic versions of data will be erased. Throughout the duration of the study, the researchers mentioned above will be the only people who have access to the data.

9. How will the results of the study be published?

Upon completion of the research, a summary of findings will be provided to those who participated. This will be emailed directly to you.

10. What if I have questions about this study?

If you would like to discuss any aspect of this study please feel free to contact

- Assoc Professor Stella Stevens on ph 03 6226 2999
- Kristen Foss on ph 03 6226 2999

"This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email

human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H12443

This information sheet is for you to keep. If you agree to participate, please sign the written consent form attached. You can email or post this back in reply paid envelope. Once this has been received by the researchers, you will be contacted to arrange an interview time and place.

National comparison of models of intensive support

Exploratory Survey

1. I agree to take part in the research study named above.
2. I have read and understood the Information Sheet for this study.
3. The nature and possible effects of the study have been explained to me.
4. I understand that the study involves the completion of an online survey that will address approximately 11 questions. I understand the basis of the questions will be around the techniques of support for people with challenging behaviour and disabilities and any restrictions in which you have been involved.
5. I understand that participation involves the risk(s) that recalling information about client specific situations may become distressing for me. I understand this type of information is not necessarily required for the study, but may occur incidentally. I understand that if I become distressed, I have the right to stop the survey without giving a reason. I also understand that if I wish for a secondary referral to be made to help address my distress I can contact the researcher and they will assist with this.
6. I understand that all research data will be securely stored on the University of Tasmania premises for five years from the publication of the study results, and will then be destroyed
7. Any questions that I have asked have been answered to my satisfaction.
8. I understand that the researcher(s) will maintain confidentiality and that any information I supply to the researcher(s) will be used only for the purposes of the research.
9. Upon completion of the research, a summary of findings will be provided to those who participated. This will be emailed directly to you
10. I understand that my participation is voluntary and that I may withdraw at any time without any effect.

If I so wish, I may request that any data I have supplied be withdrawn from the research until February 2013.

Statement by Investigator

☐ I have explained the project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have had the opportunity to contact me prior to consenting to participate in this project.

Investigator's name: Kristen Foss

Investigator's signature: _____

Date: 14/12/12

National comparison of models of intensive support

All focus group /interview /participants

Consent

1. I agree to take part in the research study named above.
2. I have read and understood the Information Sheet for this study.
3. The nature and possible effects of the study have been explained to me.
4. I understand that the study involves participation in a focus group or 1:1 interview. I understand the basis of the questions will be about my thoughts of the new disability services act and how these changes can be implemented.
5. I understand that participation involves the risk(s) that recalling information about specific situations may become distressing for me. I understand I do not have to provide any information that I might find distressing to recall. I understand that if I become distressed, I have the right to stop my participation without giving a reason. I also understand that if I wish for a secondary referral to be made to help address my distress I can contact the researcher and they will assist with this.
6. I understand that all research data will be securely stored on the University of Tasmania premises for five years from the publication of the study results, and will then be destroyed
7. Any questions that I have asked have been answered to my satisfaction.
8. I understand that the researcher(s) will maintain confidentiality and that any information I supply to the researcher(s) will be used only for the purposes of the research.
9. Upon completion of the research, a summary of findings will be provided to those who participated. This will be emailed directly to you
10. I understand that my participation is voluntary and that I may withdraw at any time without any effect.

If I so wish, I may request that any data I have supplied be withdrawn from the research until February 2013.

Participant's name: _____

Participant 's signature: _____

Date: _____

Statement by Investigator

☐

I have explained the project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐

The participant has received the Information Sheet where my details have been provided so participants have had the opportunity to contact me prior to consenting to participate in this project.

Investigator's name: _____

Investigator's signature: _____

Date: _____

Intention to attend:

Location

at

When

North

☐

North West

☐

South

I will be bringing person supported by current system/family member:

Yes

Number

Focus group- Disability Services Act 2011

Advocate, family members & those supported

Invitation

You are invited to participate in a study being conducted in Tasmania examining nationwide models of support for people with intellectual disabilities and challenging behaviour. This study is being conducted in partial fulfilment of a Doctor of Health for Kristen Foss under the supervision of Dr Stella Stevens (Associate Head, Postgraduate School of Medicine, University of Tasmania) & Professor James Vickers (Head, School of Medicine, University of Tasmania).

What is the purpose of this study?

The purpose of this study is to collate information about the models of intensive support that might exist nationwide, including exploring the issue of restrictive practices. The study will compare these models and aim collate the information into a synthesis of best practice for working with clients with challenging behaviour and intellectual disability-whose needs sit outside the mainstream government systems. The purpose of this is to determine any best practices that exist.

Why have I been invited to participate?

You have been invited to participate in this study due to your position within your organization and association with such models of support, as described above, or your advocate has identified you as a suitable respondent.

Your participation in this research is entirely voluntary. There will be no consequences if you decide not to participate. Your manager, if they identified you as a suitable participant, or anyone within your organization, will not be advised.

What will I be asked to do?

If you agree to participate, you will be asked to participate in a focus group. This group will include approximately 10 questions about your experiences with the new disability services act. More specifically, the practices of personal and environmental restrictions. You will be asked to provide your opinions about the new act and its contents. This information cannot be traced to particular person or organization.

You do not have to participate, if you decide not to, this will not affect your employment or relationship with UTAS.

If you start to participate and then change your mind, that is OK. The information that you have provided thus far can either be given back to you or destroyed, depending on what you want.

Are there any possible benefits from participation in this study?

The aims of this study are to improve those services in which we work. It is hoped that through participation in this research effective aspects of models can be collated and highlighted so that services may use this information for planning and evaluating services. Your participation in this study will assist greatly in providing such information for collation.

Are there any possible risks from participation in this study?

The questions that will be asked in this research project will be designed to elicit information about opinions of processes, procedures and theories behind the models of support rather than specific information that might lead participants to feel anxiety or distress. However it may be the case that specific instances of challenging behaviour or a client circumstances is recalled throughout this interview process. It is possible this might lead to distress.

In the event that any anxiety or distress is exhibited by you, you have the right to stop the survey process without giving a reason. There will be no consequences if you choose to terminate the interview process.

If you or the researcher consider that a referral is required to help address any distress experienced, the researcher will assist you to seek appropriate support. This will depend on what is available in your state.

What if I change my mind during or after the study?

At any stage throughout this research, you may decide to withdraw. You will not be obliged to provide any explanation if you choose to withdraw. The information that you have provided thus far can either be given back to you or destroyed, depending on what you want.

What will happen to the information when this study is over?

All data collected will be treated in a confidential manner. Names and identifying information is not required for the purpose of this study. No individual or particular organizational responses will be reported. All of the information will be kept in a locked cabinet in the office of Dr Stella Stevens, who is Kristen's supervisor, at the University of Tasmania. Kristen will keep some password protected electronic data until the review completion. All of this data will be kept for 5 years and then destroyed. The written transcripts will be shredded and the electronic

versions of data will be erased. Throughout the duration of the study, the researchers mentioned above will be the only people who have access to the data.

How will the results of the study be published?

Upon completion of the research, a summary of findings will be provided to those who participated. This will be emailed directly to you. Responses will be collated, no individual responses will be reported. No information about specific organisations will be reported.

What if I have questions about this study?

If you would like to discuss any aspect of this study please feel free to contact

- Assoc Professor Stella Stevens on ph. 03 62264683
- Kristen Foss on ph. 03 6226 2999

“This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H12443

This information sheet is for you to keep. If you agree to participate, please sign the written consent form attached. You can email or post this back.

Disability Assessment and Advisory Team Clinicians

Invitation

You are invited to participate in a study being conducted in Tasmania examining models of support for people with intellectual disabilities and challenging behaviour. This study is being conducted in partial fulfillment of a Doctor of Health for Kristen Foss under the supervision of Dr Stella Stevens (Associate Head, Postgraduate School of Medicine, University of Tasmania) & Professor James Vickers (Head, School of Medicine, University of Tasmania).

What is the purpose of this study?

The purpose of this study is to collate information about the models of support that might exist nationwide, including exploring the issue of restrictive practices. The study will compare these models and aim collate the information into a synthesis of best practice for working with clients with challenging behaviour and intellectual disability-whose needs sit outside the mainstream government systems. The purpose of this is to determine any best practices that exist.

Why have I been invited to participate?

You have been invited to participate in this study due to your position within your organization and association with such models of support. Your participation in this research is entirely voluntary. There will be no consequences if you decide not to participate. Your manager, who identified you as a suitable participant, or anyone within your organization, will not be advised.

What will I be asked to do?

If you agree to participate, you will be asked to participate in a survey. This survey will seek responses to approximately 5 questions about the new Disability Services Act. More specifically, the practices of personal and environmental restrictions. This information cannot be traced to particular person or organization.

You do not have to participate, if you decide not to, this will not affect your employment or relationship with UTAS. If you start to participate and then change your mind, that is OK. The information that you have provided thus far can either be given back to you or destroyed, depending on what you want.

Are there any possible benefits from participation in this study?

The aims of this study are to improve those services in which we work. It is hoped that through participation in this research effective aspects of models can be collated and highlighted so that

services may use this information for planning and evaluating services. Your participation in this study will assist greatly in providing such information for collation.

Are there any possible risks from participation in this study?

The questions that will be asked in this research project will be designed to elicit information about opinions of processes, procedures and theories behind the models of support and your knowledge of these, rather than specific information that might lead participants to feel anxiety or distress. However it may be the case that specific instances of challenging behaviour or a client circumstances is recalled throughout this interview process. It is possible this might lead to distress. It may be possible you feel your knowledge is insufficient to be able to provide adequate answers to these questions. This may cause you distress.

In the event that any anxiety or distress is exhibited by you, you have the right to stop the survey process without giving a reason. There will be no consequences if you choose to terminate the interview process.

If you or the researcher consider that a referral is required to help address any distress experienced, the researcher will assist you to seek appropriate support. This will depend on what is available in your state.

What if I change my mind during or after the study?

At any stage throughout this research, you may decide to withdraw. You will not be obliged to provide any explanation if you choose to withdraw. The information that you have provided thus far can either be given back to you or destroyed, depending on what you want.

What will happen to the information when this study is over?

All data collected will be treated in a confidential manner. Names and identifying information is not required for the purpose of this study. No individual or particular organizational responses will be reported. All of the information will be kept in a locked cabinet in the office of Dr Stella Stevens, who is Kristen's supervisor, at the University of Tasmania. Kristen will keep some password protected electronic data until the review completion. All of this data will be kept for 5 years and then destroyed. The written transcripts will be shredded and the electronic versions of data will be erased. Throughout the duration of the study, the researchers mentioned above will be the only people who have access to the data.

How will the results of the study be published?

Upon completion of the research, a summary of findings will be provided to those who participated. This will be emailed directly to you. Responses will be collated, no individual responses will be reported. No information about specific organisations or individuals can or will be reported.

What if I have questions about this study?

If you would like to discuss any aspect of this study please feel free to contact

- Assoc Professor Stella Stevens on ph. 03 62264683
- Kristen Foss on ph. 03 62333120

“This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H1244.

The reduction of restrictive interventions in Tasmanian Disability Services

Disability Services Act (2011) Exploratory Survey

DAAT Consent

1. I agree to take part in the research study named above.
2. I have read and understood the Information Sheet for this study.
3. The nature and possible effects of the study have been explained to me.
4. I understand that the study involves the completion of an online survey. I understand the basis of the questions will be about the implementation of the new Disability Services Act (2011) my understanding of these.
5. I understand that participation involves the risk(s) that recalling information about specific situations may become distressing for me. I understand I do not have to

provide any information that I might find distressing to recall. I understand that if I become distressed, I have the right to stop my participation without giving a reason. I also understand that if I wish for a secondary referral to be made to help address my distress I can contact the researcher and they will assist with this.

6. I understand that all research data will be securely stored on the University of Tasmania premises for five years from the publication of the study results, and will then be destroyed
7. Any questions that I have asked have been answered to my satisfaction.
8. I understand that the researcher(s) will maintain confidentiality and that any information I supply to the researcher(s) will be used only for the purposes of the research.
9. Upon completion of the research, a summary of findings will be provided to those who participated. This will be emailed directly to you
10. I understand that my participation is voluntary and that I may withdraw at any time without any effect.

If I so wish, I may request that any data I have supplied be withdrawn from the research until August 2014

Participant's name: _____

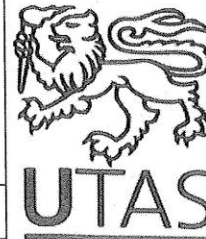
Participant 's signature: _____

Date: _____

Appendix F

Ethics Amendment applications

Social Science Ethics Officer
Private Bag 01 Hobart
Tasmania 7001 Australia
Tel: (03) 6226 2763
Fax: (03) 6226 7148
Human.ethics@utas.edu.au



HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

6 August 2013

Dr Stella Stevens
School of Medicine
Private Bag 96

Sent via email

Dear Dr Stevens

Re: APPROVAL FOR AMENDMENT TO CURRENT PROJECT
Ethics Ref: **H0012443 - A national comparison of models of intensive support**

- Additional focus groups, to include people with disabilities, their advocates and families in the data collection.
- Revised Advocate invitation letter, Client information sheet, Advocate and Family Member information sheet and consent form dated 29 July 2013.

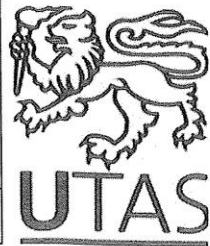
We are pleased to advise that the Chair of the Tasmania Social Sciences Human Research Ethics Committee approved the Amendment to the above project on 2 August 2013.

Yours sincerely

A handwritten signature in black ink, appearing to be 'K. Shaw', is positioned above the printed name.

Katherine Shaw
Ethics Officer
Tasmania Social Sciences HREC

Social Science Ethics Officer
Private Bag 01 Hobart
Tasmania 7001 Australia
Tel: (03) 6226 2763
Fax: (03) 6226 7148
Human.ethics@utas.edu.au



HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

24 June 2014

Dr Stella Stevens
School of Medicine
Private Bag 96

Sent via email

Dear Dr Stevens

Re: APPROVAL FOR AMENDMENT TO CURRENT PROJECT
Ethics Ref: **H0012443 - The reduction of restrictive interventions in Tasmanian Disability Services**

1. Change of title to "The reduction of restrictive interventions in Tasmanian Disability Services".
2. Addition of a survey to be disseminated to members of the Disability Assessment and Advisory Teams.
3. Addition of interview with the Senior Practitioner in Victoria.
4. Inclusion of information gathered as a part of the student researcher's professional role, from the CEOs of organisations.
4. Information Sheet and Consent Form for Senior Practitioner Interview.
5. Information Sheet and Consent Form for Clinician Survey.

We are pleased to advise that the Chair of the Tasmania Social Sciences Human Research Ethics Committee approved the Amendment to the above project on 20 June 2014.

Yours sincerely

A handwritten signature in black ink, appearing to be "KShaw", is written above the printed name of Katherine Shaw.

Katherine Shaw
Executive Officer
Tasmania Social Sciences HREC

Appendix G

Letter from Deputy Secretary

Department of Health and Human Services

Disability, Housing and Community Services - Disability and Community Services

GPO Box 125, HOBART TAS 7001 Australia

Ph: 1300 135 513

Web: www.dhhs.tas.gov.au



Contact: Kristen Webb
Phone: (03) 6233 3120
E-mail: kristen.webb@dhhs.tas.gov.au

Subject:

On three previous occasions (dated 24 November 2013, 24 February 2014 and 6 March 2014) Director of Disability and Community Services, XX asked you to report on your compliance with the *Disability Services Act 2011* (the Act) in relation to the use of restrictive interventions within your organisation. I note that you are yet to respond to these requests as well as additional email requests.

This issue has now been escalated to me to ensure that Devonfield is compliant with the Act. Failure to be compliant with the Act may result in penalties to the organisation.

It is important we have a good understanding of the progress your organisation is making in relation to the minimisation of use of restrictive interventions. Accordingly I ask you to provide a written response to the following questions:

- Does your organisation have restrictive interventions in place?
- Which of these restrictive interventions have approval under section 38 or 42, please list.
- Does your organisation have policy relating to the use of restrictive interventions?
- Does your organisation provide training for staff regarding alternatives to the use of restraint?

- Do you think the leaders and managers within your organisation as well as your staff understand the issues regarding the use of restrictive interventions and their requirements under the Act?

Please do not hesitate to contact Ms Kristen Webb-Foss if further clarification or discussion is required.

Yours sincerely

Deputy Secretary

July 2014

Appendix H
Clinician Survey

Disability Assessment and Advisory Team

Disability Services Act 2011 (TAS) (restrictive interventions) Training needs

1 Where would you rate your need for additional training/education about issues associated with the use of restrictive interventions, procedures for organisations when proposing use of restrictive interventions etc?

No need			Some need		Strong need	
1	2	3	4	5	6	7

2. If you identified the need for additional training/education, could you specify the area/type of training you might benefit from?

3. When thinking about environmental restrictions, what might be an example of this type of restriction (either an example from your professional experience, or a theoretical example). (try not to use the example of locked fridge and pantry)

4. When thinking about personal restrictions, what might be an example of this type of restriction (either an example from your professional experience, or a theoretical example).

5. Outline briefly the steps you would take if you:

(a) came across the use of a restrictive intervention in an organisation

(b) found it necessary to recommend the use of a restrictive intervention

6. Can you describe some of the risks when using restrictive interventions?

Appendix I
Disability Services Act 2011 (Tas)

Disability Services Act 2011 (No. 27 of 2011)

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Disability Services Act 2011

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Amended

60. Principal Act

61. Section 3 amended (Interpretation)

Part 11 - Poisons Regulations 2008 Amended

62. Principal Regulations

63. Regulation 3 amended (Interpretation)

Part 12 - Legislation repealed

64. Legislation repealed

Schedule 1 - Legislation repealed

Disability Services Act 2011

An Act relating to the funding of the provision of specialist disability services, and other goods or services, in relation to persons with disability, the regulation of the use of restrictive interventions in relation to such persons, the repeal of the Disability Services Act 1992, the consequential amendment of certain legislation, and for related purposes

Be it enacted by His Excellency the Governor of Tasmania, by and with the advice and consent of the Legislative Council and House of Assembly, in Parliament assembled, as follows:

PART 1 - Preliminary

1. Short title

This Act may be cited as the Disability Services Act 2011.

2. Commencement

(1) The provisions of this Act commence on a day to be proclaimed.

(2) However, if the provisions of this Act have not commenced before 1 January 2012, the provisions of this Act commence on that day.

3. Objects

The objects of this Act are

(a) to provide for the funding of

(i) the provision of specialist disability services and certain other goods or services; and

- (ii) research or development activities; and
- (b) to provide for the effective planning, prioritisation and scrutiny of the provision of specialist disability services and grants under this Act; and
- (c) to set out principles that are to be applied in relation to the performance or exercise of functions or powers under this Act and in relation to certain activities to which this Act relates; and
- (d) to enable the setting of standards that are to be met by funded disability services providers in providing, or ensuring the provision of, specialist disability services; and
- (e) to ensure that funded disability services providers provide, or ensure the provision of, specialist disability services in a manner that meets those standards; and
- (f) to regulate the use of restrictive interventions by disability services providers and funded private persons.

4. Interpretation

(1) In this Act, unless the contrary intention appears

"accommodation support services" means services which

- (a) provide accommodation to persons with disability; or
- (b) provide the support needed to enable a person with disability to remain in the person's existing accommodation;

"associated area", in relation to a funded provider's premises, means

- (a) the area, outside those premises, which is part of the property on which the premises are located; or
- (b) a room occupied, or to be occupied, by a resident of the premises; or
- (c) any common area; or
- (d) any facilities that are connected to the premises;

"authorised officer" means a person who is authorised to enter premises under section 25;

"community visitor services" means inspection of the provision of specialist disability services by disability services providers so as to ensure that

- (a) the needs of persons with disability are being appropriately met in the provision of such services; or
- (b) the rights of persons with disability are being respected in the provision of such services;

"designated standards" means

- (a) the standards that are prescribed in regulations in accordance with section 6(1); or
- (b) if those standards have not been prescribed, the standards referred to in section 6(3);

"disability", in relation to a person, means a disability of the person which

- (a) is attributable to a cognitive, intellectual, psychiatric, sensory or physical impairment or a combination of those impairments; and
- (b) is permanent or likely to be permanent; and
- (c) results in
 - (i) a substantial restriction in the capacity of the person to carry on a profession, business or occupation, or to participate in social or cultural life; and
 - (ii) the need for continuing significant support services; and
- (d) may or may not be of a chronic episodic nature;

"disability research provider" means a person or organisation that carries out research or development activities;

"disability services provider" means a person or organisation that provides, whether or not for profit, specialist disability services but does not include

- (a) a relative or friend of a person with disability who provides specialist disability services to the person; or
- (b) a prescribed person or body;

"employee", in relation to a funded provider, means

- (a) an employee or agent of the funded provider; or
- (b) a person providing services voluntarily on behalf of the funded provider;

"funded disability research provider" means a disability research provider that is receiving a grant under section 14(1)(b);

"funded disability services provider" means a disability services provider that is receiving a grant under section 14(1)(a);

"funded entity" means

- (a) a funded provider; or
- (b) a funded private person;

"funded private person" means a person who is receiving a grant under section 14(1)(c);

"funded provider" means

- (a) a funded disability services provider; or
- (b) a funded disability research provider;

"funded provider's premises" means premises

- (a) that are owned, leased or occupied by a funded disability services provider and that are used by a disability services provider as a place in or from which to provide specialist disability services; or
- (b) in which research or development activities are being carried out by a funded disability research provider

and includes an associated area;

"funding agreement" means a funding agreement entered into under Part 3

"grant" means a grant under this Act;

"Guardianship and Administration Board" means the Guardianship and Administration Board established under the Guardianship and Administration Act 1995;

"individual plan", in relation to a person with disability, means an individual plan approved under section 11 or 12 in relation to the person;

"intake and assessment services" means

- (a) initial assessment of persons to determine if they are eligible to be provided with specialist disability services; and
- (b) the identification of which specialist disability services may be required by a person who is determined to be eligible to be

provided with such services;

"intermediary services" means the provision of assistance

(a) in the determination of the needs of a person with disability;

or

(b) in organising the delivery, by a disability services provider, of specialist disability services to a person with disability; or

(c) to a person to whom a grant under section 14(1)(c) relates, to enable the grant to be effectively managed;

"operational area" means an area determined under section 8;

"operational plan", in relation to an operational area, means the plan for that area approved under section 8, as the plan is amended and in force from time to time;

"private funded premises" means

(a) premises in which resides a person to whom a grant under section 14(1)(c) is made; or

(b) premises in which resides a person with disability to whom a grant under section 14(1)(c) relates

but does not include supported accommodation;

"research or development activities" means

(a) research in relation to the provision of specialist disability services; or

(b) investigation of the need for specialist disability services; or

(c) the planning, development or implementation of specialist disability services; or

(d) the planning, development or implementation of training programs

(i) for persons engaged in the provision of specialist disability services; or

(ii) for families of persons with disability and other persons who care for or assist persons with disability; or

(e) investigation of outcomes achieved by persons with disability, or persons referred to in paragraph (d)(ii), through the provision of specialist disability services or other goods or services; or

- (f) any other activities approved by the Minister under subsection (3) in relation to specialist disability services;

"restrictive intervention" means any action that is taken to restrict the rights or freedom of movement of a person with disability for the primary purpose of the behavioural control of the person but does not include such an action that is

- (a) taken for therapeutic purposes; or
- (b) taken to enable the safe transportation of the person; or
- (c) authorised under any enactment relating to the provision of mental health services or to guardianship;

"Secretary" means the Secretary of the Department;

"specialist disability services" means services specifically for, or related to, the support of persons with disability and includes, but is not limited to including, the following:

- (a) accommodation support services;
- (b) home care and family support services;
- (c) in-home community-based services;
- (d) intake and assessment services;
- (e) independent living training services;
- (f) information services and print disability services;
- (g) recreation services;
- (h) respite care services;
- (i) education or training services;
- (j) counselling, support or advocacy services;
- (k) community visitor services;
- (l) therapy services;
- (m) equipment services;
- (n) transport services;
- (o) intermediary services

but does not include a prescribed service;

"strategic plan" means the strategic plan, approved under section 7, as the plan is in force from time to time;

"supported accommodation" means premises

- (a) at which a person with disability resides permanently or

temporarily; and

(b) that are owned, leased or occupied, in whole or in part, by a disability services provider.

(2) In this Act, a person or organisation to which a grant is made under section 14(1) is to be taken to be receiving the grant for the period specified in the funding agreement in relation to the grant as the period for which the agreement is to be in force.

(3) The Minister, in writing, may approve an activity as a research or development activity for the purposes of this Act.

(4) A reference in this Act to a person nominated by a person with disability

(a) includes, if the person with disability is a child, a reference to a parent of the child and a person acting in loco parentis; and

(b) includes a reference to a guardian or trustee of the person with disability or a person who is an administrator, within the meaning of the Guardianship and Administration Act 1995, in relation to the person with disability.

5. Principles

(1) In this section

"relevant activities" means

(a) the performance or exercise of a function or power under this Act by the Minister, the Secretary, the Senior Practitioner, the Guardianship and Administration Board, a delegate of, or a person authorised by, such a person, or an authorised officer; or

(b) the formulation of designated standards to be submitted to the Governor for the Governor to make as regulations; or

(c) the design, administration and provision of specialist disability services by a funded disability services provider; or

(d) the preparation and approval of individual plans by disability services providers or the preparation of such plans by a person nominated by a person with disability; or

(e) the carrying out of research or development activities by funded disability research providers.

(2) The following principles are to be applied in respect of relevant activities:

- (a) the needs and best interests of persons with disability are to be promoted;
- (b) so far as is practicable, and having regard to the intellectual capacity of the person with disability, decisions or actions that may directly affect a person with disability
 - (i) should only be taken after the person has been consulted; and
 - (ii) should take into account the wishes of the person, to the extent that they are consistent with the needs and best interests of the person and the safety of the person and others; and
 - (iii) should only result in the restriction of the freedom of decision and action of the person, if at all, to the smallest extent that is practicable in the circumstances;
- (c) the inherent dignity of persons with disability and their individual autonomy, including the freedom to make their own choices and their right to independence, is to be respected;
- (d) persons with disability are not to be discriminated against;
- (e) persons with disability are to be given the opportunity for full and effective participation and inclusion in society;
- (f) there is to be respect for persons being different, and acceptance of persons with disability, as part of human diversity and humanity;
- (g) persons with disability are to be given opportunities that are equal, or equivalent, to the opportunities available to persons without disability;
- (h) specialist disability services are to be as physically and technologically accessible as possible to persons with disability;
- (i) equality between men and women is to be promoted;
- (j) the fact that the capacities of children with disability may evolve as they mature, and the right of children with disability to preserve their identities as equal citizens, are to be respected.

6. Designated standards

(1) The regulations are to prescribe standards that are to apply in relation to funded disability services providers.

(2) Regulations for the purposes of subsection (1) may prescribe standards that are to apply to

- (a) all funded disability services providers in respect of the design, administration and provision of specialist disability services by disability services providers; and
- (b) a particular kind of funded disability services provider in respect of the design, administration and provision of specialist disability services by such disability services providers.

(3) Until designated standards are prescribed in regulations made under this Act, the designated standards for the purposes of this Act are to be the standards contained in Schedule 3 to the Disability Services Act 1992 as in force immediately before the commencement of this Act.

PART 2 - Planning and Reporting

Division 1 - Planning and budgetary oversight

7. Strategic plan

(1) The Minister must approve a plan (the "strategic plan") by 1 January in the first year after this section commences and by 1 January of every third year after that year.

(2) The Minister, before approving the strategic plan, is to consult with

- (a) the persons or bodies that, in the opinion of the Minister, have experience or expertise in the provision of specialist disability services; and
- (b) persons with disability and persons who care for such persons; and
- (c) the persons or bodies that, in the opinion of the Minister, represent the interests of persons with disability.

(3) The strategic plan is to set out

- (a) the outcomes intended to be achieved in the State in relation to

- (i) the administration of this Act; and
 - (ii) the provision of specialist disability services; and
 - (iii) grants provided under this Act; and
- (b) how it is proposed that the outcomes are to be achieved.
- (4) The strategic plan is to set out
- (a) the objectives that are to be achieved across the State as a whole; and
 - (b) the objectives that are to be achieved in particular parts of the State set out in the strategic plan.
- (5) The strategic plan is to set out
- (a) the proportion of any funding, appropriated by Parliament in relation to persons with disability, that is to be used in the administration of this Act; and
 - (b) the proportion of any funding, appropriated by Parliament in relation to persons with disability, that is to be used to enable grants to be made.

(6) The strategic plan is to set out how the proportion of funding referred to in subsection (5)(b) is to be distributed between

- (a) grants to disability services providers under section 14(1)(a); and
- (b) grants to disability research providers under section 14(1)(b); and
- (c) grants to persons under section 14(1)(c).

(7) The strategic plan is to set out how the proportion of funding that is to be distributed as grants under section 14(1)(a) is to be distributed between different kinds of specialist disability services.

(8) The strategic plan is to set out how the proportion of funding that is to be distributed for the purposes set out in subsection (6)(a), (b) and (c) is to be distributed for those purposes between the particular parts of the State set out in the strategic plan in accordance with subsection (4)(b).

(9) The strategic plan may include other matters that the Minister thinks fit in respect of matters to which this Act relates.

(10) The Secretary is to ensure that an up-to-date copy of the strategic plan is available for viewing or purchase by the public.

8. Operational plans

(1) The Secretary is to determine whether

(a) the State is to be regarded as one operational area for the purposes of this Act; or

(b) the State is to be divided into more than one operational area for the purposes of this Act.

(2) The Secretary is to approve, and review and amend from time to time as he or she thinks fit, a plan (the "operational plan") for the operational area, or each of the operational areas, determined under subsection (1).

(3) The Secretary, before approving or amending an operational plan, and in reviewing such a plan, is to consult with

(a) the persons or bodies that, in the opinion of the Secretary, have experience or expertise in the provision of specialist disability services; and

(b) persons with disability and persons who care for such persons; and

(c) the persons or bodies that, in the opinion of the Secretary, represent the interests of persons with disability.

(4) An operational plan in relation to an operational area is to set out

(a) how the strategic plan is to be implemented in the operational area; and

(b) how funding that is to be used in respect of the operational area in accordance with the strategic plan is to be distributed between

(i) the costs of administering this Act in that operational area; and

(ii) the making of grants to persons or organisations in the operational area; and

(c) how funding that is to be distributed in respect of the operational area in the making of grants to persons or organisations in the operational area is to be distributed between

(i) grants to disability services providers under section 14(1)(a); and

(ii) grants to disability research providers under section 14(1)(b)

; and

(iii) grants to persons under section 14(1)(c).

(5) The operational plan in relation to an operational area is to set out how the proportion of funding that is to be distributed in respect of the operational area as grants to disability services providers under section 14(1)(a) is to be distributed between different kinds of specialist disability services.

(6) The operational plan for an operational area is to include

(a) how the objectives that are specified in the strategic plan to be objectives to be achieved across the State as a whole are to be implemented in the operational area; and

(b) how the objectives that are specified in the strategic plan to be objectives to be achieved in a particular part of the State, specified in the strategic plan, that is in the operational area are to be implemented in that part of the State.

(7) The Secretary is to ensure that an up-to-date copy of each operational plan is available for viewing or purchase by the public.

(8) An operational plan may form part of a document containing plans in relation to matters other than matters to which this Act relates.

9. Budgetary oversight

(1) The Secretary, as soon as practicable after the end of a financial year, must prepare an annual report in respect of the financial year.

(2) The annual report in respect of a financial year is to

(a) set out how the strategic plan as in force for the financial year was implemented, in each of the operational areas, in accordance with the operational plan for that operational area; and

(b) set out the extent to which the outcomes, referred to in section 7

(3), set out in the strategic plan as in force for the financial year, have been achieved, if at all; and

(c) specify the amount appropriated by Parliament that was used for the purposes of the administration of this Act and the amount appropriated by Parliament that was used in the making of grants; and

(d) detail how the amount used for the purposes of the administration

of this Act was distributed between the operational areas; and
(e) detail how the amount that was used in the making of grants was distributed during that year between

- (i) different kinds of specialist disability services; and
 - (ii) research or development activities; and
 - (iii) grants to persons under section 14(1)(c); and
 - (iv) each operational area; and
- (f) specify, in relation to each funded entity, the amounts that were provided by way of grants under this Act; and

(g) contain the prescribed information, if any.

(3) The annual report is not to contain the name or address of a person with disability.

(4) The Minister is to lay a copy of the annual report before each House of Parliament by 31 October next following the end of the financial year to which the annual report relates.

(5) If the Minister is unable to comply with subsection (4) within the period referred to in that subsection because either House of Parliament is not sitting at the expiration of that period, the Minister is to

- (a) forward a copy of the annual report to the Clerk of that House of Parliament before the expiration of that period; and
- (b) lay a copy of the annual report before that House within the next 7 sitting-days of that House.

Division 2 - Individual plans

10. Contents of individual plans

An individual plan in relation to a person with disability is a plan that includes

- (a) the outcomes that it is intended be attained by the person through the provision to the person of specialist disability services or the provision of other goods or services; and
- (b) the specialist disability services, and other goods or services, that may be required in order to attain those outcomes; and
- (c) any specialist disability services, or other goods or services,

- that may require financing under a grant; and
- (d) the rights and responsibilities of the person and any disability services provider or funded private person that provides specialist disability services to the person; and
- (e) the period for which the plan is to be in force; and
- (f) the prescribed matters, if any.

11. Approval of individual plans required by term or condition of grant to funded private persons

(1) This section applies to a person if a term or condition, imposed in accordance with section 17(3), of a grant to the person requires that there be an individual plan in relation to the person with disability to whom the grant relates.

(2) A proposed individual plan in relation to a person with disability to whom this section applies, or an amendment to such a plan, is to be prepared by or on behalf of the person after consultation between

- (a) the person, or if a person is nominated by the person with disability, the nominated person; and
- (b) the Secretary.

(3) A person to whom this section applies or, if a person is nominated by the person with disability, the nominated person, may provide to the Secretary a copy of

- (a) a proposed individual plan in relation to the person with disability; or
- (b) a proposed amendment to an individual plan approved under subsection (4) in relation to the person.

(4) The Secretary may approve in relation to a person with disability

- (a) an individual plan in relation to the person that is provided to the Secretary under subsection (3); or
- (b) an amendment, to an individual plan in relation to the person, that is provided to the Secretary under subsection (3).

12. Approval of individual plans required by term or condition of grant to

provider

(1) This section applies to a person with disability and a funded disability services provider if

- (a) the provider is providing specialist disability services to the person; and
- (b) a term or condition, imposed in accordance with section 15(3), of a grant to the provider requires that there be an individual plan in relation to the person.

(2) A proposed individual plan in relation to a person with disability to whom this section applies, or an amendment to such a plan, is to be prepared by or on behalf of the person after consultation between

- (a) the person, or, if a person is nominated by the person with disability, the nominated person; and
- (b) the funded disability services provider.

(3) A person with disability to whom this section applies, or, if a person is nominated by the person with disability, the nominated person, may provide to the funded disability services provider a copy of

- (a) a proposed individual plan in relation to the person; or
- (b) a proposed amendment to an individual plan approved under subsection (4) in relation to the person.

(4) A person authorised by a funded disability services provider to approve individual plans may approve in relation to a person with disability

- (a) an individual plan in relation to the person that is provided to the funded disability services provider under subsection (3); or
- (b) an amendment, to an individual plan in relation to a person with disability, that is provided to the funded disability services provider under subsection (3).

PART 3 - Funding

13. Provision of specialist disability services

(1) The Secretary may provide assistance in respect of the provision of specialist disability services to a person with disability.

(2) In providing assistance to a person with disability the Secretary may

(a) provide specialist disability services

(i) indirectly to the person through disability services providers;

or

(ii) directly to the person; or

(b) take the necessary action to encourage persons and organisations to provide specialist disability services to persons with disability who require the services.

(3) The Secretary must not provide specialist disability services directly to any person under subsection (2)(a)(ii) unless the Secretary is satisfied that the provision of the services complies with

(a) the principles set out in section 5; and

(b) the designated standards that apply to a disability services provider that provides such services.

14. Grants

(1) The Secretary may make a grant to

(a) a person or organisation for the purpose of enabling the person or organisation to provide specialist disability services; or

(b) a person or organisation for the purpose of enabling the person or organisation to carry out any research or development activity; or

(c) a person with disability, or a person nominated by a person with disability to whom the grant is to relate, for the purpose of enabling the provision of

(i) specialist disability services; or

(ii) other goods or services

necessary or desirable to remediate the disadvantage, or difficulties, associated with the person's disability, that are experienced by the person with disability to whom the grant relates or persons who care for the person.

(2) A grant may only be made under subsection (1)(a) to a person or organisation if

(a) the person or organisation has entered into a funding agreement

under section 15 in relation to the grant; and

(b) the Secretary is satisfied that the person or organisation will comply with

(i) the principles set out in section 5; and

(ii) the designated standards that apply to disability services providers providing such services

(3) A grant may only be made under subsection (1)(b) to a person or organisation if

(a) the person or organisation has entered into a funding agreement under section 16 in relation to the grant; and

(b) the Secretary is satisfied that the person or organisation will, in conducting the research or development to which the grant relates, comply with the principles set out in section 5

(4) A grant may only be made under subsection (1)(c) to a person if

(a) the person has entered into a funding agreement under section 17 in relation to the grant; and

(b) the Secretary is satisfied that any specialist disability services that are to be purchased using the grant will be purchased from disability services providers who will comply with

(i) the principles set out in section 5; and

(ii) the designated standards that apply to disability services providers providing such services.

(5) Grants under subsection (1) are to be made out of money appropriated by Parliament for the purpose.

(6) A grant may be made by way of

(a) a lump sum; or

(b) periodic payments as determined by the Secretary.

15. Funding agreements with disability services providers

(1) A person or organisation may enter into a funding agreement with the Secretary in relation to a grant to the person or organisation for the purposes of enabling the person or organisation to provide specialist disability services.

(2) A funding agreement, with a person or organisation referred to in subsection (1), in relation to a grant must specify

- (a) the specialist disability services to be provided by the person or organisation for the purposes of the grant; and
- (b) that it is a condition of the grant that the person or organisation, so far as is practicable, must, in the design, administration and provision of any specialist disability services for the purposes of the grant, comply with
 - (i) the principles set out in section 5; and
 - (ii) the designated standards that apply to disability services providers providing such services; and
- (c) the terms and other conditions of the grant with which the person or organisation must comply in providing specialist disability services for the purposes of the grant; and
- (d) the period for which the agreement is to be in force.

(3) Without limiting the generality of subsection (2)(c), a funding agreement with a person or organisation in relation to a grant may specify that it is a term or condition of the grant that the person or organisation will ensure that there is, or will be, an individual plan in relation to

- (a) each person with disability to whom specialist disability services are provided by the person or organisation; or
- (b) each person with disability who will be receiving specialist disability services of a kind, specified in the term or condition, that are provided by the person or organisation.

(4) A funded disability services provider, as soon as practicable after each 12-month period in which there is an individual plan in relation to a person with disability because of a term or condition of the kind referred to in subsection (3), must review the plan to determine if the plan may require amendment.

16. Funding agreements with disability research providers

(1) A person or organisation may enter into a funding agreement with the Secretary in relation to a grant to the person or organisation for the purposes of carrying out any research or development activity.

(2) A funding agreement, with a person or organisation referred to in subsection (1), in relation to a grant must specify

- (a) the research or development activities to be carried out by the

person or organisation for the purposes of the grant; and

(b) that it is a condition of the grant that the person or organisation, so far as is practicable, must, in carrying out the research or development activities, comply with the principles set out in section 5; and

(c) the terms and other conditions of the grant with which the person or body must comply in respect of the research or development activity; and

(d) the period for which the agreement is to be in force.

17. Funding agreements with funded private persons

(1) A person may enter into a funding agreement with the Secretary in relation to a grant to the person under section 14(1)(c) for the purpose of enabling the provision of

(a) specialist disability services; or

(b) other goods or services

necessary or desirable to remediate the disadvantage, or difficulties, associated with the person's disability, that are experienced by the person with disability to whom the grant relates or persons who care for the person.

(2) A funding agreement in relation to a grant to a person under section 14(1)(c) must specify

(a) the specialist disability services, or other goods or services, that are to be financed in whole or in part by the grant; and

(b) the outcomes that it is intended are to be achieved by the provision of the specialist disability services or other goods or services; and

(c) the terms and conditions of the grant; and

(d) the rights under the funding agreement of the person with whom the agreement is entered into and the person with disability to whom the grant relates; and

(e) the period for which the agreement is to be in force.

(3) Without limiting the generality of subsection (2)(c), a funding agreement in relation to a grant to the person under section 14(1)(c) may

specify that it is a term or condition of the grant that there is, or will be, an individual plan in respect of the person with disability to whom the grant relates.

18. Amendment of funding agreement

(1) The Secretary, by notice in writing to a person or organisation, may amend a funding agreement entered into by the person or organisation.

(2) A funding agreement may only be amended under subsection (1) with the approval of the person or organisation that entered into the agreement.

PART 4 - Monitoring of Grants

Division 1 - Review of grants

19. Review of grants to funded disability services providers

(1) The Secretary, at least once every 3 years during a period in which a funded disability services provider is receiving a grant, must conduct a review of the grant.

(2) In reviewing a grant to a funded disability services provider the Secretary must consider, in addition to any other matters the Secretary thinks fit, whether the provider has

- (a) so far as is practicable, complied with the principles set out in section 5; and
- (b) complied with the designated standards that apply to such funded disability services providers; and
- (c) otherwise complied with the terms and conditions of the grant set out in the financial agreement in relation to the grant.

(3) In reviewing a grant to a funded disability services provider, the Secretary must consider, in addition to any other matters the Secretary thinks fit, the extent to which the grant has enabled the quality of life of persons with disability to be improved.

20. Review of grants to funded disability research providers

(1) The Secretary must conduct a review of a grant that is being or has been received by a funded disability research provider.

(2) In reviewing a grant to a funded disability research provider the

Secretary must consider, in addition to any other matters the Secretary thinks fit, whether the provider has

- (a) so far as is practicable, complied with the principles set out in section 5; and
- (b) otherwise complied with the terms and conditions of the grant.

21. Review of use being made of grant to funded private person

(1) The Secretary, at least once each year during which a funding agreement is in force in relation to a grant to a funded private person, must conduct a review of the grant.

(2) In reviewing a grant to a funded private person, the Secretary must consider, in addition to any other matters the Secretary thinks fit

- (a) the use that has been made of the grant; and
- (b) the extent to which the person has complied with the terms and conditions of the grant; and
- (c) the extent to which the quality of life of the person with disability to whom the grant relates has been improved by the grant; and
- (d) the extent to which
 - (i) the individual plan in relation to the person with disability to whom the grant relates may require amendment; and
 - (ii) obligations of any other person, including but not limited to disability services providers, for the provision of goods or services in relation to the person with disability to whom the grant relates have been fulfilled; and
 - (iii) there is adequate coordination of the delivery of services, including but not limited to specialist disability services, in relation to the person with disability to whom the grant relates.

(3) Despite subsection (1), the Secretary is not required to conduct a review in relation to a grant to a funded private person if the Secretary is of the opinion that

- (a) the person may otherwise provide proof of the use that has been made of the grant and compliance with any terms and conditions of the grant; and
- (b) the specialist disability services, or other goods or services, to

which the grant relates are such that a review of the matters referred to in subsection (2)(d) is unnecessary.

Division 2 - Monitoring

22. Provision of assistance to enable compliance with terms and conditions of grant

(1) If the Secretary is of the opinion that a funded entity is failing to comply with a term or condition of a grant that the entity is receiving, the Secretary may

(a) discuss with the funded entity how the Secretary may assist the entity to comply with the term or condition by providing to the entity

(i) training, or access to training; or

(ii) the services of persons with specialist skills; or

(iii) other assistance; and

(b) provide to the funded entity any appropriate assistance to enable the entity to comply with the term or condition of the grant.

(2) The appropriate assistance that may be provided to a funded entity under subsection (1)(b) is

(a) training, or access to training; or

(b) the provision of the services of persons with specialist skills; or

(c) any other assistance that the Secretary considers appropriate.

23. Requirements must be imposed on entity if non-compliance continues

(1) The Secretary must give notice in writing to a funded entity if

(a) the entity

(i) has refused to discuss with the Secretary under section 22(1)

(a) how the Secretary may assist the entity to comply with a term or condition of a grant to the entity; or

(ii) has refused, without reasonable cause, to accept an offer by the Secretary to provide assistance to the entity under section 22

(1)(b); and

(b) the Secretary is of the opinion that the entity is continuing to fail to comply with the term or condition.

- (2) A notice to a funded entity under subsection (1) is to
- (a) specify the term or condition that, in the Secretary's opinion, the entity is failing to comply with; and
 - (b) specify the requirements, for the entity to take action or to cease to take action, that the Secretary proposes to require the entity to comply with; and
 - (c) invite the entity to make written submissions to the Secretary within 28 days after receiving the notice.

(3) A funded entity to which a notice is given under subsection (1) may, within 28 days after receiving the notice, make a submission in writing to the Secretary.

(4) A submission made by a funded entity under subsection (3) may contain

- (a) a statement
 - (i) as to the reasons why the entity believes that the opinion of the Secretary may be in error; or
 - (ii) disputing a ground on which the Secretary's opinion is based; and
- (b) a statement as to why the requirements that the Secretary proposes to require the entity to comply with cannot or should not be complied with; and
- (c) any other information that the entity thinks fit.

(5) The Secretary, after considering a submission, if any, made by a funded entity under subsection (3) in relation to a notice received by the entity under subsection (1), may, by notice in writing to the entity, require the entity to take the relevant action.

(6) For the purposes of subsection (5), the relevant action is the requirements specified in the notice under subsection (1), as those requirements have been modified, if at all, in response to the submission.

24. Failure of entity to comply with requirement

- (1) This section applies in relation to a funded entity if
 - (a) the entity fails to comply with a requirement of a notice given to the entity under section 23(5) in relation to a term or condition of a grant to the entity; and

(b) the Secretary is of the opinion that the entity is continuing to fail to comply with the term or condition.

(2) The Secretary may

(a) terminate the funding agreement in relation to a funded entity to which this section applies; or

(b) with the consent of a funded entity to which this section applies, appoint, for a period of not more than 90 days, a person as administrator of

(i) the services to be provided by the funded entity for the purposes of the grant; or

(ii) the research or development to be carried out by the funded entity for the purposes of the grant.

(3) If a funding agreement in relation to a funded entity is terminated, the entity must return to the Secretary, within 90 days, the balance of any grant to which the funding agreement relates that is outstanding at the date of the termination.

Division 3 - Entry of premises

25. Secretary may authorise entry of premises

(1) The Secretary, in writing, may authorise a State Service employee or State Service officer to enter funded provider's premises, or private funded premises, or both.

(2) An authorisation under this section may relate to

(a) particular funded provider's premises or particular private funded premises; or

(b) funded provider's premises generally or private funded premises generally.

(3) An authorisation under this section may be subject to conditions or limitations specified in the authorisation.

26. Rights of authorised officers to enter premises

(1) An authorised officer who is authorised under section 25(1) to enter premises may enter the premises specified in the authorisation.

(2) An entry of premises under subsection (1) may only be made for

the purposes of

- (a) determining the extent to which the terms and conditions of a funding agreement are being complied with; or
- (b) ensuring that persons with disability who reside in, or receive specialist disability services in, the premises are receiving the care and support that is necessary or desirable for their health and wellbeing; or
- (c) ensuring the safety of persons with disability who reside at, or receive specialist disability services in, the premises.

(3) An authorised officer may enter funded provider's premises under subsection (1) at any time without prior warning to the owner of, or any occupier of, the premises.

(4) An authorised officer who enters funded provider's premises under subsection (1) must ensure that, if he or she enters a part of the premises, designated for the private use of a person with disability, while the person is present in the part of the premises, the authorised officer immediately tells the person the purposes for which the authorised officer has entered the premises.

(5) An authorised officer who enters premises under subsection (1) must, at the request of a person on the premises, show the person proof that the officer is authorised to enter the premises, or leave the premises as soon as practicable after the request is made.

(6) An authorised officer is not authorised to use force to enter premises under this Act.

(7) A police officer may, at the request of an authorised officer who would only be able to enter premises for the purposes of this section by using force, use such force as is reasonably necessary to enable the authorised officer to enter the premises.

27. Additional requirements where private funded premises entered

(1) An authorised officer may enter private funded premises under section 26(1) only if he or she has made reasonable attempts to give at least 48 hours' prior notice to a person who resides at the premises.

(2) Despite subsection (1), an authorised officer is not required to make reasonable attempts to give at least 48 hours' prior notice to a

person who resides at private funded premises if the officer is reasonably of the opinion that it is necessary to enter the premises without notice in order to ascertain

- (a) whether a person with disability is receiving the care and support that is necessary or desirable for the person's health and wellbeing;
- or

- (b) whether a person with disability is safe.

(3) An authorised officer may only enter private funded premises under section 26(1) before 7 a.m., or after 7 p.m., if it is reasonably necessary to do so in order to ascertain whether

- (a) the person with disability is receiving, at the premises, or from a person who resides at the premises, the care and support that is necessary or desirable for the health and wellbeing of the person; or
- (b) a person with disability is safe.

(4) An authorised officer who enters private funded premises under section 26(1) must as soon as practicable tell a person on the premises, and any person with disability on the premises, the purpose for which the authorised officer has entered the premises.

28. Rights of authorised officers after entry of premises

(1) An authorised officer who enters premises under section 26(1) may take any of the following actions on the premises, in so far as it is necessary to do so for the purposes for which, under section 26(2), the officer has entered the premises

- (a) inspect the premises;
- (b) open any container, filing cabinet, or storage facility, that is on the premises;
- (c) request a person on the premises to provide documents or records to the officer;
- (d) inspect any documents or records on the premises;
- (e) take copies of, or request a person on the premises to make copies of, any documents or records that are on the premises or provided to the officer.

(2) An authorised officer who enters premises under section 26(1) may

request

- (a) any employee of the funded provider, if any, in respect of the premises and any person who is receiving a grant under section 14(1)(c); or
- (b) any person with disability, or other person, who is on the premises

to answer questions in relation to the provision of specialist disability services or other goods or services to which the grant relates, or the carrying out of research or development, by the provider.

(3) A person with disability who is requested under subsection (2) to answer questions is entitled to

- (a) request that another person be present when the person with disability answers the questions; and
- (b) have another person be present, and to be assisted by that other person, when answering the questions.

(4) If an authorised officer has entered premises under section 26(1), the funded provider providing services at the premises, any employee of the funded provider and any person (other than a person with disability) who is receiving a grant under section 14(1)(c)

- (a) must permit the authorised officer to ask employees of the provider, or any person who is on the premises, questions in relation to

- (i) the provision of specialist disability services or other goods or services to which the grant relates; or
 - (ii) the carrying out by the provider of research or development;
- and

- (b) must not

- (i) prohibit a person of whom a question is asked under paragraph (a) from answering the question; or
 - (ii) threaten or punish a person of whom a question is asked under paragraph (a) if the person answers or were to answer such a question; and
- (c) must permit an authorised officer to speak in private with employees of the provider or any person who is on the premises.

(5) A funded provider, any employee of a funded provider and any person (other than a person with disability) who is receiving a grant under section 14(1)(c) must not impede an authorised officer from performing or exercising the authorised officer's functions or powers under this Act.

(6) If a funded provider, an employee of a funded provider or any person (other than a person with disability) who is receiving a grant under section 14(1)(c)

(a) fails to comply with a request made of the funded provider, employee or person, respectively, under subsection (2); or

(b) fails to comply with a requirement of subsection (5)

the failure may be taken into account in determining whether or not a grant to the funded provider or the person may be terminated or refused.

PART 5 - Senior Practitioner

29. Senior Practitioner to be appointed

(1) The Secretary is to appoint a State Service employee or State Service officer to be the Senior Practitioner.

(2) A person may only be appointed to be the Senior Practitioner if, in the opinion of the Secretary, the person has appropriate qualifications and experience to perform the functions and exercise the powers of the Senior Practitioner under this Act.

30. Functions and powers of Senior Practitioner

(1) The functions of the Senior Practitioner are

(a) to advise the Secretary in relation to the provision of specialist disability services; and

(b) to make recommendations to the Secretary as to how the provision of specialist disability services may be improved; and

(c) any other functions specified by or under this Act.

(2) In addition to any other power that may be exercised by the Senior Practitioner under this Act, the Senior Practitioner has the powers necessary to perform the functions of the Senior Practitioner.

31. Annual report

- (1) The Senior Practitioner must provide to the Secretary, by 1 September in each year, a report consisting of
- (a) information on the performance of the functions, and the exercise of the powers, of the Senior Practitioner during the previous financial year; and
 - (b) data relating to the use of restrictive interventions during the previous financial year.

(2) A report provided to the Secretary under subsection (1) must not enable a person with disability to be identified.

(3) The Secretary must ensure that a copy of the report provided to the Secretary under subsection (1) is available to the public at an electronic website of the Department for at least 12 months after it is so provided.

32. Senior Practitioner may delegate functions, &c.

(1) The Senior Practitioner may delegate to a State Service employee or State Service officer a power or function of the Senior Practitioner, other than this power of delegation.

(2) The Senior Practitioner may only delegate a power or function under subsection (1) to a person who

- (a) in the opinion of the Senior Practitioner has sufficient knowledge and expertise in respect of persons with disability; and
- (b) has appropriate skills and qualifications in respect of the power or function.

33. Persons to provide assistance to Senior Practitioner, &c.

(1) The Senior Practitioner may require a disability services provider, any employee of the provider, and a funded private person, to provide the Senior Practitioner with any reasonable assistance that the Senior Practitioner may require to perform a function or exercise a power of the Senior Practitioner in the disability services provider's premises or the private funded premises of the funded private person.

(2) A disability services provider, any employee of the provider and a funded private person

- (a) must not fail to provide reasonable assistance when required to do so under subsection (1); and

(b) must give full and true answers to the best of the provider's, employee's or funded private person's knowledge, respectively, to any question asked by the Senior Practitioner in the performance or exercise of a function or power of the Senior Practitioner under this Act.

Penalty:

Fine not exceeding 200 penalty units.

PART 6 - Regulation of Restrictive Interventions

Division 1 - Preliminary provisions

34. Interpretation of Part 6

In this Part

"environmental restriction", in relation to a person with disability, means a restrictive intervention in relation to the person that consists of the modification of an object, or the environment of the person, so as to enable the behavioural control of the person but does not include a personal restriction;

"personal restriction", in relation to a person with disability, means a restrictive intervention in relation to the person that consists wholly or partially of

(a) physical contact with the person so as to enable the behavioural control of the person; or

(b) the taking of an action that restricts the liberty of movement of the person.

35. Functions of Senior Practitioner in relation to restrictive interventions

The functions of the Senior Practitioner in relation to restrictive interventions under this Act are as follows:

- (a) to develop, in relation to restrictive interventions, guidelines, and standards, that are in accordance with best practice;
- (b) to provide education and information in relation to restrictive interventions and the use of behaviour management techniques that may obviate or minimise the need for restrictive interventions;
- (c) to provide information in relation to the rights of persons with disability who may be subject to restrictive interventions;
- (d) to give advice to the Secretary, the Guardianship and Administration Board, disability services providers and funded private persons, so as to
 - (i) improve practices in relation to restrictive interventions and the use of behaviour management techniques that may obviate or minimise the need for restrictive interventions; and
 - (ii) enable the use of restrictive interventions to be reduced and, where appropriate, eliminated;
- (e) to undertake research in relation to restrictive interventions and to make recommendations to the Secretary in respect of the need for research in relation to restrictive interventions;
- (f) to monitor and evaluate the use of restrictive interventions.

36. Use of unauthorised restrictive intervention prohibited

(1) A disability services provider or a funded private person must ensure that a type of restrictive intervention is not carried out in relation to a person with disability who is under the care or control of the disability services provider or a funded private person

- (a) unless, if the person with disability is not a person to whom paragraph (b) relates
 - (i) there is in force an approval under section 38 or section 42 for the carrying out of the type of restrictive intervention in relation to the person; and
 - (ii) the restrictive intervention is carried out in accordance with any conditions or limitations specified in the approval; and
 - (iii) the restrictive intervention does not contravene a direction, if any, under section 47 in relation to the carrying out of the restrictive intervention in relation to the person; or

(b) if there is a relevant authorisation in relation to the person with disability, except if the restrictive intervention is the restrictive intervention authorised under that authorisation.

Penalty:

Fine not exceeding 200 penalty units.

(2) It is a defence to a charge of an offence against subsection (1) in relation to a person with disability if

- (a) the disability services provider or funded private person establishes that the carrying out of the restrictive intervention in relation to the person with disability was required to protect the person with disability, or another person, from serious harm; and
- (b) the restrictive intervention carried out was the least intrusive type of restrictive intervention that would have protected the person with disability, or another person, from serious harm; and
- (c) the Senior Practitioner was notified by the disability services provider or funded private person as soon as practicable after the restrictive intervention was carried out; and
- (d) no restrictive intervention, other than under an approval under section 38 or section 42, was carried out in relation to the person with disability after 72 hours after the restrictive intervention was first carried out in relation to the person; and
- (e) there is no relevant authorisation in relation to the person with disability.

(3) For the purposes of this section, there is a relevant authorisation in relation to a person with disability if there is, in relation to the person, an authorisation by the Chief Forensic Psychiatrist under the Mental Health Act 1996, or an authorisation under another enactment, which

- (a) authorises the carrying out of an action by the Chief Forensic Psychiatrist, or another person acting under the authority of the Chief Forensic Psychiatrist, which action, but for paragraph (a) or (c) of the definition of "restrictive intervention" in section 4, would be a restrictive intervention; or

(b) authorises the Chief Forensic Psychiatrist, or another person, to carry out in relation to the person an action that is a restrictive intervention.

(4) A reference in subsection (3) to an authorisation to carry out an action includes an order, direction, permission, requirement, or any other authority, to carry out the action.

Division 2 - Approvals by Secretary

37. Applications for approvals to carry out restrictive interventions

(1) A disability services provider or funded private person may apply to the Secretary for an approval under section 38.

(2) An application under subsection (1) is to be in a form approved by the Secretary.

38. Approvals to carry out restrictive interventions

(1) The Secretary, after receiving under section 37(1) an application from a disability services provider or funded private person, may grant, or refuse to grant, approval for the provider or person to carry out, in relation to a person with disability specified in the approval, a type of restrictive intervention, specified in the notice, that is an environmental restriction.

(2) An approval may only be granted under subsection (1) by notice in writing to

(a) the disability services provider, or funded private person, to whom the approval is granted; and

(b) the person with disability to whom the approval relates.

(3) An approval for the carrying out of a type of restrictive intervention in relation to a person with disability may only be granted by the Secretary under subsection (1) if the Secretary is satisfied that consultation on the Secretary's behalf with

(a) the person or a person nominated by the person; and

(b) persons, if any, who have expertise in the carrying out of restrictive interventions of that type; and

(c) the Senior Practitioner

has occurred and the Secretary has taken into account matters raised in that consultation.

(4) An approval for the carrying out of a type of restrictive intervention in relation to a person with disability may only be granted by the Secretary under subsection (1) if the Secretary is satisfied that

- (a) the type of restrictive intervention will be carried out only for the primary purpose of ensuring the safety, health or wellbeing of the person or other persons; and
- (b) the restrictive intervention is the type of restrictive intervention that is the least restrictive of the person's freedom of decision and action as is practicable in the circumstances.

(5) In determining whether to grant an approval under this section for the carrying out by a disability services provider or funded private person of a type of restrictive intervention in relation to a person with disability, the Secretary must have regard to

- (a) the best interests of the person with disability; and
- (b) the consequences to the person with disability if restrictive intervention of that type is carried out in relation to the person; and
- (c) the consequences to the person with disability, or other persons, if restrictive intervention of that type is not carried out in relation to the person with disability; and
- (d) any alternative method reasonably suitable and able to be used in relation to the person with disability to control the behaviour for which the type of restrictive intervention has been proposed; and
- (e) the nature and degree of any significant risks to the person with disability if the restrictive intervention is carried out; and
- (f) whether, and the extent to which, carrying out the restrictive intervention will promote or reduce the safety, health and wellbeing of the person with disability.

39. Provisions in respect of approvals by Secretary

(1) An approval under section 38 may be granted subject to the conditions or limitations specified in the approval.

(2) Without limiting the generality of subsection (1), an approval under section 38 may be granted on the condition that reports, in relation

to the carrying out of restrictive interventions of the type authorised under the approval, are given to the Secretary, at the times, or in the circumstances, specified in the condition, by the disability services provider or funded private person to whom the approval is granted.

(3) An approval under section 38 expires 90 days after it is granted.

(4) Nothing in this Act is to be taken to prevent the granting of more than one approval under section 38 in relation to the same person with disability.

(5) The Secretary may not delegate under any Act his or her functions or powers under this Division.

40. Review, amendment and revocation of approval by Secretary of restrictive interventions

(1) If the Secretary has granted an approval under section 38, the Secretary may, at any time

(a) of his or her own motion; or

(b) on application by, or on behalf of, a person with disability to whom the approval relates or a person nominated by the person; or

(c) on application by the disability services provider, or funded private person, to whom the approval is granted

review the approval.

(2) The Secretary, after reviewing an approval granted under section 38, may, by notice in writing to

(a) the disability services provider or funded private person to whom the approval was granted; and

(b) the person with disability to whom the approval relates or a person nominated by the person

amend or revoke the approval.

(3) The Secretary may only amend or revoke an approval granted by the Secretary under section 38 if the Secretary is satisfied that consultation on the Secretary's behalf with

(a) the disability services provider or funded private person to whom the approval was granted; and

(b) the person with disability to whom the approval relates or a person nominated by the person

has occurred and the Secretary has taken into account matters raised in that consultation.

(4) A person with disability to whom an approval under section 38 relates, or a person nominated by the person, may apply to the Guardianship and Administration Board for a review of the approval granted by the Secretary

(5) If an application is made under subsection (4) in relation to an approval

(a) the approval is taken to be an approval granted under section 42 by the Guardianship and Administration Board after a hearing was held by the Board; and

(b) the application is to be treated as an application under section 45 for a review of the approval.

Division 3 - Approvals by Guardianship and Administration Board

41. Applications for approvals to carry out restrictive interventions

(1) A disability services provider or funded private person may apply to the Guardianship and Administration Board for an approval under section 42.

(2) An application under subsection (1)

(a) is to be in writing; and

(b) is to specify the name of the person with disability to whom the approval is to relate; and

(c) is to contain a statement from the Senior Practitioner as to why he or she is of the opinion that the Guardianship and Administration Board ought to grant the approval sought; and

(d) is to contain the prescribed information; and

(e) is to be lodged with the registrar within the meaning of the Guardianship and Administration Act 1995.

42. Approvals to carry out restrictive interventions

(1) The Guardianship and Administration Board, after receiving under section 41 an application from a disability services provider or funded private person, may grant, or refuse to grant, approval for the provider or person to carry out in relation to a person with disability specified in the approval

- (a) a type of restrictive intervention, specified in the notice, that is a personal restriction; or
- (b) a type of restrictive intervention, specified in the notice, that is an environmental restriction.

(2) An approval may be granted under subsection (1) by notice in writing to

- (a) the disability services provider, or funded private person, to whom the approval is granted; and
- (b) the person with disability to whom the approval relates.

(3) An approval for the carrying out of a type of restrictive intervention in relation to a person with disability may only be granted by the Guardianship and Administration Board under subsection (1) by notice in accordance with subsection (2) if the Board has consulted with

- (a) the person or a person nominated by the person; and
- (b) persons, if any, who have expertise in the carrying out of restrictive interventions of that type.

(4) An approval may be granted under subsection (1) at the conclusion of a hearing for the purposes of subsection (5).

(5) The Guardianship and Administration Board may hold a hearing in respect of an application under section 41 for an approval.

(6) For the purposes of subsection (5), a hearing is to be held under Division 1 of Part 10 of the Guardianship and Administration Act 1995 as if a reference in that Division

- (a) to an application were a reference to an application for an approval under this section; and
- (b) to medical or dental treatment were a reference to a restrictive intervention; and
- (c) to a registered practitioner were a reference to the disability services provider, or funded private person, who made the application.

(7) At the hearing of an application for the purposes of subsection (5), the Guardianship and Administration Board, in addition to granting or refusing to grant an approval under subsection (1), may

- (a) require a party to the hearing to provide to the Board any information required to be contained in an application under section 19

of the Guardianship and Administration Act 1995; and

(b) make an order under section 20(1) of the Guardianship and Administration Act 1995 appointing a full or limited guardian in relation to the person with disability to whom the approval relates, as if the application for an approval under this section were an application under section 19 of the Guardianship and Administration Act 1995.

43. Circumstances in which approvals may be granted

(1) An approval for the carrying out of a type of restrictive intervention in relation to a person with disability may only be granted by the Guardianship and Administration Board under section 42 if the Board is satisfied that

- (a) the type of restrictive intervention will be carried out only for the primary purpose of ensuring the safety, health or wellbeing of the person or other persons; and
- (b) the restrictive intervention is the type of restrictive intervention that is the least restrictive of the person's freedom of decision and action as is practicable in the circumstances.

(2) In determining whether to grant an approval under section 42 for the carrying out by a disability services provider or funded private person of a type of restrictive intervention in relation to a person with disability, the Guardianship and Administration Board must have regard to

- (a) the best interests of the person with disability; and
- (b) the consequences to the person with disability if restrictive intervention of that type is carried out in relation to the person; and
- (c) the consequences to the person with disability, or other persons, if restrictive intervention of that type is not carried out in relation to the person with disability; and
- (d) any alternative method reasonably suitable and able to be used in relation to the person with disability to control the behaviour for which the type of restrictive intervention has been proposed; and
- (e) the nature and degree of any significant risks to the person with disability if the restrictive intervention is carried out; and
- (f) whether, and the extent to which, carrying out the restrictive

intervention will promote or reduce the safety, health and wellbeing of the person with disability.

44. Provisions in respect of approvals by Guardianship and Administration Board

(1) An approval under section 42 may be granted subject to the conditions or limitations specified in the approval.

(2) Without limiting the generality of subsection (1), an approval under section 42 may be granted on the condition that reports, in relation to the carrying out of restrictive interventions of the type authorised under the approval, are given to the Guardianship and Administration Board, at the times, or in the circumstances, specified in the condition, by the disability services provider or funded private person who made the application for the approval.

(3) An approval under section 42 expires 90 days after it is granted, unless it is granted at the conclusion of a hearing in accordance with section 42(5), in which case it expires after 6 months or a shorter period, if any, specified in the approval.

(4) Nothing in this Act is to be taken to prevent the granting of more than one approval under section 42 in relation to the same person with disability.

45. Review, amendment and revocation of approval by Guardianship and Administration Board

(1) An application for a review of an approval granted under section 42 may be made to the Guardianship and Administration Board by

- (a) a person with disability to whom the approval relates or a person nominated by the person; or
- (b) the disability services provider, or funded private person, to whom the approval was granted.

(2) The Guardianship and Administration Board

- (a) on its own motion; or
- (b) on application by, or on behalf of, a person with disability to whom the approval relates or a person nominated by the person; or
- (c) on application by the disability services provider, or funded private person, to whom the approval was granted

may review an approval granted under section 42.

(3) If an approval was granted under section 42 without a hearing being held, the Guardianship and Administration Board may, by notice in writing to

(a) the disability services provider or funded private person to whom the approval was granted; and

(b) the person with disability to whom the approval relates
amend or revoke the approval.

(4) The Guardianship and Administration Board may only amend or revoke an approval granted by the Board under section 42 without a hearing being held if the Board has consulted with

(a) the disability services provider or funded private person to whom the approval was granted; and

(b) the person with disability to whom the approval relates or a person nominated by the person.

(5) If an approval was granted under section 42 after a hearing, the Guardianship and Administration Board may only amend or revoke the approval at the conclusion of a hearing for the purposes of subsection (6) of a review in respect of the approval.

(6) The Guardianship and Administration Board may hold a hearing of a review in respect of an approval granted under section 42.

(7) For the purposes of subsection (6), a hearing of a review is to be held under Division 1 of Part 10 of the Guardianship and Administration Act 1995 as if a reference in that Division

(a) to an application were a reference to an application referred to in subsection (2)(b) or (c); and

(b) to an application were, where the hearing of a review is held of the Board's own motion, a reference to the decision of the Board to hold the hearing of the Board's own motion; and

(c) to medical or dental treatment were a reference to a restrictive intervention; and

(d) to a registered practitioner were a reference to the disability

services provider, or funded private person, to whom the approval to which the review relates was granted.

(8) The Guardianship and Administration Board, at the conclusion of a hearing in accordance with subsection (6) to review an approval granted under section 42 to a disability services provider or funded private person, may amend or revoke the approval.

Division 4 - Investigations and directions

46. Senior Practitioner to investigate, &c., use of restrictive interventions

(1) If the Senior Practitioner believes on reasonable grounds that a type of restrictive intervention is being carried out by a disability services provider or funded private person, the Senior Practitioner may

- (a) visit and inspect any part of the premises of the provider or any part of the funded private premises on which the restrictive intervention is being carried out; and
- (b) observe and speak to a person who is subject to a restrictive intervention being carried out by the provider or funded private person; and
- (c) investigate, audit and monitor the carrying out of a restrictive intervention by the provider or funded private person; and
- (d) inspect and make copies of, or take extracts from, any document that
 - (i) relates to a person who is subject to a restrictive intervention being carried out by the provider or funded private person; and
 - (ii) may be relevant to determining whether it is necessary to impose a restrictive intervention or determining the type of restrictive intervention that may be necessary to impose; and
- (e) question a person involved in the development, implementation or application of such restrictive interventions; and
- (f) request the provider or funded private person to provide information relating to a restrictive intervention carried out by the

provider or funded private person.

(2) The Senior Practitioner must provide a report to the Secretary in relation to the exercise of any powers under subsection (1) in relation to a disability services provider or funded private person.

(3) If the Secretary is of the opinion that a restrictive intervention, in relation to a person with disability, to which a report provided to the Secretary under subsection (2) relates is a restrictive intervention authorised by an approval granted under section 42 by the Guardianship and Administration Board, the Secretary must provide a copy of the report to the Guardianship and Administration Board.

47. Directions may be issued in relation to restrictive interventions

(1) The Secretary, after considering a report provided to him or her under section 46(2) in relation to a disability services provider or funded private person, may, by notice in writing to the provider or funded private person, direct the provider or funded private person to do either or both of the following:

- (a) to discontinue a restrictive intervention that has not been authorised by an approval under section 38 or section 42;
- (b) to observe a practice or procedure, specified in the notice, in the carrying out of a restrictive intervention that has been authorised by an approval granted by the Secretary under section 38.

(2) The Guardianship and Administration Board, after considering a report provided to the Board under section 46(3) in relation to a disability services provider or funded private person, may, by notice in writing to the provider or person, direct the provider or person to observe a practice or procedure, specified in the notice, in the carrying out of a restrictive intervention that has been authorised by an approval granted by the Board under section 42.

(3) The Secretary may only give a direction under subsection (1) if the Secretary has considered the matters referred to in section 38(4) or (5).

(4) The Guardianship and Administration Board may only give a direction under subsection (2) if the Board has considered the matters

referred to in section 43.

(5) A disability services provider or funded private person to whom a direction under subsection (1) or (2) is given must not fail to comply with the direction.

Penalty:

Fine not exceeding 200 penalty units.

(6) If a direction is given under subsection (1) to discontinue a restrictive intervention or a practice or procedure used in a restrictive intervention, the Senior Practitioner must provide assistance in developing alternative strategies for the management of the behaviour of the person in respect of whom the restrictive intervention is to be used.

(7) The Secretary must as soon as practicable advise in writing a person with disability in respect of whom a restrictive intervention is to be used, or a person nominated by the person, of a direction given under subsection (1) in relation to the restrictive intervention.

(8) The Guardianship and Administration Board must as soon as practicable advise in writing a person with disability in respect of whom a restrictive intervention is to be used, or a person nominated by the person, of a direction given under subsection (2) in relation to the restrictive intervention.

(9) A direction given under this section in relation to a person with disability that is inconsistent with an approval under section 38 or section 42 in relation to the person is invalid to the extent of the inconsistency.

PART 7 - Miscellaneous

48. Review by Magistrates Court (Administrative Appeals Division)

(1) A person with disability to whom an individual plan relates or is to relate may apply to the Magistrates Court (Administrative Appeals Division) for a review of a decision by the Secretary, or a person authorised by a funded disability services provider, to approve, or not to approve, a proposed individual plan in relation to the person under section 11 or 12.

(2) A person with disability, a disability services provider, or a funded private person, to whom an approval under section 38 relates may

apply to the Magistrates Court (Administrative Appeals Division) for a review of

- (a) the decision under that section to grant the approval; or
- (b) a decision under section 39(1) to impose a condition or limitation on the approval; or
- (c) a decision under section 40 to amend or revoke the approval.

(3) A person with disability, a disability services provider, or a funded private person, to whom a direction under section 47 relates may apply to the Magistrates Court (Administrative Appeals Division) for a review of the decision under that section to give the direction.

(4) A person on whom a requirement specified in a notice under section 23 has been imposed may apply to the Magistrates Court (Administrative Appeals Division) for a review of the decision by the Secretary to impose the requirement.

49. Secretary to be responsible for coordination of services

The Secretary is to take reasonable steps to assist in the effective coordination of the provision of the following services for persons with disability:

- (a) specialist disability services;
- (b) health and psychiatric services;
- (c) specialist education services;
- (d) other services that are provided by or on behalf of Tasmania or the Commonwealth for the purpose of providing special assistance to persons with disability.

50. Sharing of information

(1) In this section

"information-sharing entity" means

- (a) a prescribed person; or
- (b) a State Service officer or State Service employee employed in or for the purposes of the Department or another department, within the meaning of the Administrative Arrangements Act 1990; or
- (c) a manager of a private medical establishment, within the meaning of the Hospitals Act 1918 or of an establishment to which a licence under the Health Service Establishments Act 2006 relates;

or

(d) a controlling authority of an approved hospital, assessment centre, or secure mental health unit, each within the meaning of the Mental Health Act 1996; or

(e) the person in charge of a funded disability services provider;

or

(f) the person in charge of an organisation that receives funding from the Secretary under a funding agreement to provide drug or alcohol treatment services; or

(g) the person in charge of an organisation that receives a referral from the Secretary or a Community-Based Intake Service, within the meaning of the Children, Young Persons and Their Families Act 1997; or

(h) the Chief Forensic Psychiatrist; or

(i) any other person, or organisation, prescribed in the regulations;

"prescribed person" means

(a) a medical practitioner; or

(b) a registered nurse or enrolled nurse; or

(c) a person registered under the Health Practitioner Regulation National Law (Tasmania) in

(i) the midwifery profession; or

(ii) the dental profession as a dentist, dental therapist, dental hygienist or oral health therapist; or

(iii) the psychology profession; or

(d) a police officer; or

(e) a probation officer appointed or employed under section 5 of the Corrections Act 1997; or

(f) principal or a teacher in any educational institution (including a kindergarten); or

(g) a person who provides child care, or a child care service, for fee or reward; or

- (h) a person concerned in the management of a child care service licensed under the Child Care Act 2001; or
- (i) any other person who is employed or engaged as an employee for, of or in, or who is a volunteer in
 - (i) an Agency, within the meaning of the State Service Act 2000, that provides health, welfare, education, child care or residential services wholly or partly for children; or
 - (ii) an organisation that receives any funding from the Crown for the provision of such services;

"relevant person" means a person with disability to whom goods or services are being, or have been, provided under a grant.

(2) Subject to subsection (3), the Secretary may

- (a) provide information to an information-sharing entity; or
- (b) require an information-sharing entity to provide information to the Secretary.

(3) The Secretary may only provide information in relation to a relevant person, or require information in relation to a relevant person to be provided to the Secretary, if the Secretary is satisfied that

- (a) the information is necessary
 - (i) to enable an appropriate assessment of the needs of the person to be ascertained; or
 - (ii) to determine whether any goods or services provided, or to be provided, to the person are appropriate; or
- (iii) for the safety, welfare or wellbeing of the person or the safety of other persons; and
- (b) where the person with disability is capable of giving his or her consent to the provision of the information to another person and the information is not required for the safety of the person or other persons, the person with disability has given that consent.

(4) An information-sharing entity required to provide information to the Secretary under subsection (2) must, within the period specified by the Secretary

- (a) provide the information; or
- (b) if the information-sharing entity does not have the information, provide the Secretary with notice in writing that it cannot provide the information for that reason.

Penalty:

Fine not exceeding 5 penalty units.

(5) An information-sharing entity may do either or both of the following in relation to information in its possession in relation to a relevant person:

- (a) provide the Secretary with the information, whether or not the Secretary has required the information to be provided;
- (b) provide another information-sharing entity with the information if that entity is involved with, or is likely to be involved with, the person or a person who is related to the person.

(6) An information-sharing entity may only provide under subsection (5) to an information-sharing entity information in relation to a relevant person if

- (a) it is satisfied that it is necessary to do so
 - (i) to enable an appropriate assessment of the needs of the person to be made; or
 - (ii) to determine whether any goods or services provided, or to be provided, to the person are appropriate; or
 - (iii) for the safety, welfare or wellbeing of the person or the safety of other persons; and
- (b) where the person with disability is capable of giving his or her consent to the provision of the information to another person and the information is not required for the safety of the person or other persons, the person with disability has given that consent.

(7) A person providing information under this section

- (a) cannot, by virtue of providing the information, be held to have breached any code of professional etiquette or ethics, to have departed from any accepted standards of professional conduct or to have contravened any Act; and
- (b) to the extent that he or she has acted in good faith, incurs no

civil or criminal liability in respect of providing the information.

51. Immunity

(1) This section applies to

- (a) the Minister; and
- (b) the Secretary; and
- (c) the Senior Practitioner; and
- (d) the Guardianship and Administration Board; and
- (e) any delegate of, or person authorised by, the Minister, the Secretary or the Senior Practitioner; and
- (f) an authorised officer.

(2) An action does not lie against any person to whom this section applies in respect of any act done in good faith and in the performance, or purported performance, of a function imposed, or the exercise, or purported exercise, of a power conferred, by or under this Act.

52. Regulation

(1) The Governor may make regulations for the purposes of this Act.

(2) Without limiting the generality of subsection (1), the regulations may

- (a) prescribe fees and charges for the purposes of this Act; and
- (b) prescribe standards in accordance with section 6 in relation to the design, administration and provision of specialist disability services.

(3) The regulations may be made so as to apply differently according to matters, limitations or restrictions, whether as to time, circumstance or otherwise, specified in the regulations.

53 Review of Act

(1) The Minister is to cause an independent review of the operation of this Act to be carried out as soon as practicable after the third anniversary of its commencement.

(2) The persons who carry out the review are to give the Minister a written report on its outcome.

(3) The Minister is to cause a copy of the report to be tabled in each House of Parliament within 10 sitting-days of that House after it is given to the Minister.

(4) In this section

"independent review" means a review carried out by persons who

- (a) in the Minister's opinion, are appropriately qualified for that task; and
- (b) include one or more persons who are not employees of the State or Commonwealth or of any agency of the State or Commonwealth.

54. Administration of Act

Until provision is made in relation to this Act by order under section 4 of the Administrative Arrangements Act 1990

- (a) the administration of this Act is assigned to the Minister for Human Services; and
- (b) the department responsible to that Minister in relation to the administration of this Act is the Department of Health and Human Services.

55. Savings and transitional

- (1) In this section

"repealed Act" means the Disability Services Act 1992.

- (2) A grant or a funding agreement given or entered into under the repealed Act continues in force as if it were given or entered into under this Act.

PART 8 - Children, Young Persons and Their Families Act 1997 Amended

56. Principal Act

In this Part, the Children, Young Persons and Their Families Act 1997 is referred to as the Principal Act.

57. Section 3 amended (Interpretation)

Section 3(1) of the Principal Act is amended by omitting paragraph (e) from the definition of "information-sharing entity" and substituting:

- (e) the person in charge of an organisation that
 - (i) is a disability services provider within the meaning of the Disability Services Act 2011; and
 - (ii) receives funding under a funding agreement, within the meaning of that Act, to provide specialist disability services to a child; or

PART 9 - Mental Health Act 1996 Amended

58. Principal Act

In this Part, the Mental Health Act 1996 is referred to as the Principal Act.

59. Section 73 amended (Mail)

Section 73(1) of the Principal Act is amended by omitting paragraph (n) from the definition of "exempt correspondent" and substituting:

(n) the Senior Practitioner within the meaning of the Disability Services Act 2011; and

PART 10 - Obstetric and Paediatric Mortality and Morbidity Act 1994 Amended

60. Principal Act

In this Part, the Obstetric and Paediatric Mortality and Morbidity Act 1994 is referred to as the Principal Act.

61. Section 3 amended (Interpretation)

Section 3 of the Principal Act is amended by omitting "Disability Services Act 1992" from the definition of "relevant Minister" and substituting "Disability Services Act 2011".

PART 11 - Poisons Regulations 2008 Amended

62. Principal Regulations

In this Part, the Poisons Regulations 2008 are referred to as the Principal Regulations.

63. Regulation 3 amended (Interpretation)

Regulation 3(1) of the Principal Regulations is amended as follows:

- (a) by omitting "Disability Services Act 1992" from the definition of "disability" and substituting "Disability Services Act 2011";
- (b) by omitting "Disability Services Act 1992" from the definition of "funding agreement" and substituting "Disability Services Act 2011";
- (c) by omitting the definition of "service provider" and substituting the following definition:

"service provider", in relation to a disability, has the same

meaning as "disability services provider" has in the Disability Services Act 2011;

PART 12 - Legislation repealed

64. Legislation repealed

The legislation specified in Schedule 1 is repealed.

Appendix J

Locking Fridges and Pantries

Fact Sheet

Locking of fridges and pantries

Fact sheet

This information sheet aims provides some assistance when considering locking access to the fridges and pantries of people being supported under the Disability Services Act 2011(Tas.) (the Act). This practice may be defined as ‘environmental’ restrictive interventions under the Act. **Free access to food and drink is a basic human right.**

Definition of environmental restrictive intervention

Environmental restriction in relation to a person with disability means a restrictive intervention in relation to the person that consists of the modification of an object, or environment of the person, so as to enable the behavioural control of the person but does not include a personal restriction.

Therefore locking access to a person’s food, their pantry or fridge may be considered a restrictive intervention. If this is in place without appropriate approval, your organisation may be acting in contravention of the legislation.

An environmental restrictive intervention requires approval from the Secretary of DHHS or Guardianship and Administration Board via the Senior Practitioner.

Why lock access to people’s food

Sometimes service providers, organisations or workers consider this necessary for a variety of reasons. For example some of the people we support may have Pica (eating inedible substances); Prader-Willi (which may lead to constant food craving) or workers may think a person is overweight and should go on a diet. However, in spite of these reasons, which may be determined as being in the best interests of the person being supported, approval is still required prior to locking access to food. *This is the case, even if a doctor has recommended the practice.*

What do I need to do?

- Initially, alternative solutions need to be considered. Look for ways a person can have as much independence as safely possible. For example, is it possible to get a smaller fridge which contains safe/ healthy foods and drink which can be easily accessed by the person?
- Consideration needs to be given to other people in the environment who may wish to access food independently. What impact will the locking up of food have upon them?
- Advice from a Speech and Language Pathologist may need to be sought- for example, a Mealtime Management Plan may be required.
- Dieticians advice may be required, particularly if considering restricting access to food.
- Doctors examination/recommendations may be sought.
- A behaviour support plan may be necessary to assess the situation and determine alternatives. An assessment of behaviour and a multi element behavioural plan will usually help to eliminate the need for a restrictive intervention. Singh, Lancioni, Singh, Winton, Singh, McAleavey & Atkins (2008) for example, demonstrated the use of mindfulness techniques helped to manage the cravings of a person with Prader-Willi.
- It is important to consider the seeking of food may not always be about appetite, but instead serve an alternative function for the person.
- Support with communication may be required
 - People may take more food than is safe or healthy if they do not have a method to ask about food, or to get information about food and meal routines- for example;
 - A person may not have a way of knowing how much time will pass until the next meal (a few minutes? A day?). Limited access to food in the past may make hoarding food seem necessary to them.
 - The person may not know when they will have their favourite food again. This may seem like a good reason to get the item when it is available.
 - The person may not know if their supply of food is safe from others (will it be taken away by another person or a well-meaning staff person?) The person may have experienced this in the past, even if it is

no longer the case. This may be another reason to get the food whenever it is available.

- The person may not always eat enough food at one mealtime sitting (for example may have trouble concentrating, swallowing, sensory issues, fatigue and so on). They may not have a way to indicate they need help getting food when genuinely hungry, or that they need to access small amounts of food consistently throughout the day.
- **Detailed information can be provided to the Senior Practitioner to help inform the decision about whether or not the practice is considered restrictive. The Senior Practitioner can provide advice on the next steps the organisation need to take.**

Can I seek advice?

Yes, you can always access advice Office of the Senior Practitioner. Phone 61663692 or 61663567

How do I apply for approval for use of restrictive intervention? Please contact the Office of the Senior Practitioner or look at the website for the approval process.

For further information

The Office of the Senior Practitioner- seniorpractitionerdisability@dhhs.tas.gov.au

Website http://www.dhhs.tas.gov.au/disability/senior_practitioner

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